HAMBLIN
DERMATOLOGY

MEDICAL • SURGICAL • COSMETIC

928 532 7546

Patient Information

Please answer all questions

Name: Last_____ **First**_____ **MI**_____

Birthdate_____ **Age**____ **SS#**_____ **Sex** M F

Address_____ **Preferred Language**_____

City_____ **State**_____ **Race** White/Caucasian Black/African American

Zip Code_____ **4 digit** _____ Asian Hawaiian/Pacific Islander

Home Phone _____ Other Race American Indian/Alaskan

Mobile Phone_____ **Ethnic Origin** Hispanic Non-Hispanic

Work Phone_____ **Ext** _____

Email_____ **Marital Status** S [ ] M [ ] D [ ] W [ ]

How did you hear about us?_____

Primary Care Physician _____

Insurance Information

1) Insurance Co_____ **2) Insurance Co**_____

Subscriber Name_____ **Subscriber Name**_____

Relationship to Patient_____ **Relationship to Patient**_____

SS# or ID#_____ **SS# or ID#**_____

Insured's Date of Birth_____ **Insured's Date of Birth**_____

Employer_____ **Employer**_____

Responsible Party

Name_____ **Relation**_____

Birthdate_____ **SS#**_____

Address_____ **City/State**_____ **Zip**_____

Home Phone_____ **Mobile Phone**_____ **Work Phone**_____

Employer_____ **Address**_____

(1) Payment is required for all services at the time they are rendered; this may include but not be limited to a co-payment, co-insurance, or your bill in full if your insurance is one we do not file.

(2) I authorize the release of medical and personal information which may include but is not limited to: processing of medical claims and referring to other physicians.

(3) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required).

(4) My right to payment for all procedures, tests, and nursing/ physician services including major medical benefits is hereby assigned to Hamblin Dermatology. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment is given to Hamblin Dermatology.

(5) I agree to indemnify, defend and hold Hamblin Dermatology harmless from any loss, damages, costs, or expenses in connection with false insurance information provided by patient.

Emergency Contact: _____ **Relation:**_____ **Phone:**_____

Patient Signature:_____ **Date:**_____

Pharmacy of Choice:_____

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History and Intake Form

Reason For Todays Visit:_____

Past Medical History

Anxiety	Y/N	Diabetes	Y/N	Leukemia	Y/N
Arthritis	Y/N	End Stage Renal Disease	Y/N	Lung Cancer	Y/N
Asthma	Y/N	GERD/Acid Reflux	Y/N	Lymphoma	Y/N
Atrial Fibrillation	Y/N	Hearing Loss	Y/N	Prostate Cancer	Y/N
Bone Marrow Transplantation	Y/N	Hepatitis	Y/N	Radiation Treatment	Y/N
BPH/Benign Prostate Enlargement	Y/N	Hypertension/High Blood Pressure	Y/N	Seizures	Y/N
Breast Cancer	Y/N	HIV/AIDS	Y/N	Stroke	Y/N
Colon Cancer	Y/N	High Cholesterol	Y/N	**Other:**	
COPD	Y/N	Hyperthyroidism	Y/N		
Coronary Artery Disease	Y/N	Hypothyroidism	Y/N		

Past Surgical History: (Please list any surgeries within the past five years)

_____

Skin Disease History:

Acne	Y/N	Dry Skin	Y/N	Poison Ivy	Y/N
Actinic Keratoses	Y/N	Eczema	Y/N	Precancerous Moles	Y/N
Asthma	Y/N	Flaking or Itchy Scalp	Y/N	Psoriasis	Y/N
Basal Cell Skin Cancer	Y/N	Hay Fever or Allergies	Y/N	Squamous Cell Skin Cancer	Y/N
Blistering Sunburns	Y/N	Melanoma	Y/N	Other	Y/N
		If YES, was any imaging done related to the melanoma?	Y/N		

Do you currently wear sunscreen? Y/N SPF _____ Do you currently use tanning beds? Y/N

Do you have a FAMILY history of any skin cancer? Y/N Who?_____ What type? _____

Medications: (Please enter all current medications and their dosage and frequency) **Select if no medications ☐ NONE**

_____

_____

Drug Allergies:(Please enter all allergies and reactions experienced)**Select if no Drug Allergies: ☐ NONE**

Please list drug and the reaction:_____

_____

Social History:

Currently smokes Y/N Drinks Alcohol Y/N Last Flu Shot_____ N/A

Former Smoker Y/N Drinks per Week _____ Pneumonia Vaccine Y/N

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Do you have the following?

☐ Power of Attorney (Surrogate Decision Maker) ☐ Living Will (Advance Care Plan) ☐ Skilled Nursing Facility

☐ Home Health ☐ Hospice ☐ None

Review of Systems: Are you currently experiencing any of the following?

Pacemaker	Y/N	Scarring (keloid/Hypertrophic)	Y/N	Muscle Weakness	Y/N
Defibrillator	Y/N	Immunosuppression	Y/N	Neck Stiffness	Y/N
Artificial Joints (within 2 yrs.)	Y/N	Changing Mole	Y/N	Night Sweats	Y/N
Artificial Heart Valve	Y/N	Rash	Y/N	Seizures	Y/N
Meds Required Prior to Procedure	Y/N	Abdominal Pain	Y/N	Shortness of Breath	Y/N
Adhesive Allergy	Y/N	Anxiety	Y/N	Sore Throat	Y/N
Allergy to Topical Antibiotics	Y/N	Bloody Stool	Y/N	Thyroid Problems	Y/N
Blood Thinners	Y/N	Bloody Urine	Y/N	Unintentional Weight Loss	Y/N
Pregnant or Planning Pregnancy	Y/N	Blurry Vision	Y/N	Wheezing	Y/N
Allergy to Lidocaine	Y/N	Chest Pain	Y/N	Aching, Burning, Tired Legs	Y/N
Rapid Heartbeat to Epinephrine	Y/N	Cough	Y/N	Leg Discoloration	Y/N
Yeast Infections With Antibiotics	Y/N	Depression	Y/N	Leg Swelling or Inflammation	Y/N
GI Upset With Antibiotics	Y/N	Fever or Chills	Y/N	Night Cramps	Y/N
Breastfeeding	Y/N	Headaches	Y/N	Restless Leg Syndrome	Y/N
Bleeding Problems	Y/N	Joint Aches	Y/N	Varicose Veins	Y/N
Problems Healing	Y/N				
Other:					

Are you interested in Cosmetic or Aesthetic Services (Lasers, Fillers, Injectables, Peels, Product, etc.)? Y/N

Which Specific Service?_____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _____, have been offered a copy of the Hamblin Dermatology Notice of Privacy.

_____ ___/___/_____
Patient Signature (or Guardian) Date

For a copy of our HIPAA guidelines please ask the receptionist

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

Home Phone

_____O.K. to leave a detailed message?

Mobile Phone

_____O.K. to leave a detailed message?

*Cell number you can be reached on _____

Work Phone

_____O.K. to leave a detailed message?

Spouse/Other & Relation

_____O.K. to leave a detailed message and disclosing confidential medical information.

Please note; you have the right to review the Notice of Privacy Practices which provides information about how Hamblin Dermatology may use and disclose your personal health information (PHI). You may also revoke or change your consent in writing at any time.

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Patient / Guardian Signature:_____ Date:____/____/_____

Printed Name of Patient:_____

Printed Name of Guardian and
Relationship to Patient (if applicable):_____

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hamblindermatology.com
(Mozilla Firefox – Browser)

OFFICE POLICIES
WRITTEN ACKNOWLEDGMENT FORM

APPOINTMENTS: Patients are seen by appointment. For urgent and acute situations, we often schedule "work-in" appointments. Work-in appointments are made to address one acute problem, only so that patients with scheduled appointments are not kept waiting. Except in emergencies, patients with scheduled appointments will be seen before "work-in" patients. We apologize in advance for any unforeseeable delay you may experience. We will call to confirm appointments two days in advance. If you are more than 15 minutes late by our clock, you will be asked to reschedule your appointment. Cancellations must be made 24 hours prior to your appointment. **We charge $25.00 for missed appointments.**
Cancellations for surgical appointments including MOHS surgery must be made 48 hours prior to your appointment. **A fee of $200.00 may apply if a 48 hour notice is not given.**

SOCIAL SECURITY NUMBERS: We handle patients' social security numbers and personal information in a confidential manner, but we may release personal and medical information to another doctor's office in the event of a referral. We use social security numbers for insurance and billing purposes. This is required information that we ask from each of our patients.

INSURANCE: Insurance is a contract between you and your insurance company. We are actually not involved in that contract. Therefore, we cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, labs, or other charges. Currently, we file claims for Aetna/Cofinity, AHCCCS, AZ Foundation, BCBS – AZ, Cigna, Coventry/First Health, Health Net, HCA/HCG, Health Choice, Humana, Medicare, Multiplan/RAN, United Health Care; Commercial & Medicare Solutions, Community & State and Tricare. For all other insurances, we will provide you with the required information so you can file your claim with your insurance company. If we are nonparticipating with your insurance plan, than you will be responsible for payment at the time the services are provided. If you have an insurance that has a co-payment, our office policy is to collect this before services are rendered. Also, if there is any change in your insurance carrier, it is your responsibility to inform us prior to your appointment. You must have a current insurance card for us to file your insurance. If you do not have your card at the time of your appointment, you will be expected to pay in full if you wish to be seen, or your appointment can be rescheduled.

MINORS: All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave children unattended in the waiting area.

PAYMENT: Payment is due from each patient at the time of service. We accept several different kinds of payment options. We gladly accept cash, check, Visa, Master Card and Discover. If you are 18 years of age or older, we will not bill a parent or guardian - you will be responsible for the amount due at the time of service. Patients with co-pays, deductibles, percentages, etc. are expected to pay at the time of their appointment. Simply put, payment of any portion of your bill that you are responsible for "out of pocket" is expected at the time of your appointment. There will be a $35.00 service fee on all returned checks.

PHONE CALLS: You may need to contact the office with a question. In the event we are unable to answer your call immediately, please provide a return phone number where you can be reached. In case of an emergency, please dial 911 first.

AFTER HOURS PROBLEMS: We are on call 24 hours a day, available only for urgent issues that can't wait for the office to open the next business day. To contact us, please call the office number.

Referring Physicians & possibly other physicians will be updated of your care unless you **circle**: Do Not Update

ACKNOWLEDGMENT: I have read, understand, and agree to follow the above office policies.

Patient / Guardian Signature_____ Date____/____/_____

Printed Name of Patient_____

Printed Name of Guardian and
Relationship to Patient (if applicable):_____

(***ADMINISTRATION WILL PROVIDE FOR THE OFFICE PORTAL***)

User Name_____

Password_____

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MEDICARE PATIENT REGISTRATION

Please answer the following questions by placing a check in the appropriate column:

Yes	No	
☐	☐	Do you have an insurance policy that replaces Medicare? (i.e.; Atrio, Regency, MedAdvantage)
☐	☐	Are you or your spouse still working?
☐	☐	Are you being treated for this condition at the VA (Veteran's Administration)?
☐	☐	Is this condition covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Are you receiving Medicaid?

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of Medicare insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____/_____/_____

Signature as it appears on Medicare card Date

If you have a supplemental policy and it is a supplemental policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____

Signature as it appears on Medicare card Date