HAMBLIN
DERMATOLOGY

MEDICAL • SURGICAL • COSMETIC

Show Low Location 928.532.7546 - Safford Location 928.424.7546

Patient Information

Please answer all questions

Name: Last__________________________ **First**__________________________ **MI**__________
Birthdate__________________**Age**______________ **Sex:** (circle one) M F **Marital Status** S [ ] M [ ] D [ ] W [ ]
SS# ____**Preferred Language**__________________________
Mailing Address__________________________ **City**__________________________ **State**______ **Zip**________
Physical Address:__________________________ **City**__________________________ **State**______ **Zip**________
Home Phone __________________________ **Race** White/Caucasian Black/African American
Mobile Phone__________________________ Asian Hawaiian/Pacific Islander
Work Phone________________________ **Ext** ________________ American Indian/Alaskan Other________________
Email__________________________ **Ethnic Origin** Hispanic Non-Hispanic
How did you hear about us?__________________________
Primary Care Physician __________________________
Employer __________________________

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
(MUST be completed if patient is a minor)

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/Guardian Signature:____ **Date:**________________

Pharmacy of Choice: ____

HAMBLIN
DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC
Show Low Location 928.532.7546 - Safford Location 928.424.7546

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: ____

If Marked Y for Melanoma: When was it treated?_________Where on body was it located?____________________

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

Name: ____ **DOB:** ______________________________

HAMBLIN
DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC
Show Low Location 928.532.7546 - Safford Location 928.424.7546

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?____

Name: ____ **DOB:** ___________________________

HAMBLIN
DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC
Show Low Location 928.532.7546 - Safford Location 928.424.7546

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

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

____ ____/____/__________
Patient / Guardian Signature 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):____

HAMBLIN
DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC
Show Low Location 928.532.7546 - Safford Location 928.424.7546

OFFICE POLICIES
WRITTEN ACKNOWLEDGMENT FORM

APPOINTMENTS: Patients are seen by appointment. We will call/text to confirm appointments. If you are more than 15 minutes late by our clock, you may be asked to reschedule your appointment. For urgent and acute situations, we often schedule "work-in" appointments. **Work-in appointments are made to address ONE acute problem**, if you have other problems to address, we will make you an additional appointment. Except in emergencies, patients with scheduled appointments will be seen before "work-in" patients.

Cancellations must be made 24 hours prior to your appointment. **You may be charged $25.00 for missed/late cancel 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: All personal information is handled in a confidential manner and according to all applicable laws. 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: All Co-pays will be collected before services are rendered. Insurance is a contract between you, your employer and your insurance company. We are not involved in that contract and therefore, cannot become involved in disputes between regarding deductibles, co-payments, labs, or other charges. We are contracted with the following insurance companies: Aetna, AHCCCS, AZ Complete Care, AZ Foundation, BCBS–AZ, Care 1st of AZ, Cigna, Coventry/First Health, Health Net, Humana, Medicare, Multiplan/RAN, Steward Health Choice, Tricare, and United Health Care. If your insurance is not listed check with them to see if we are IN-NETWORK. We will file your claim with your insurance company but cannot know how it will process until it is submitted and reviewed by your insurance company. If we are nonparticipating/out of network with your insurance plan, you may be responsible for payment at the time the services are provided. **It is your responsibility to inform us prior to your appointment of any changes to your insurance**. You must have a current insurance card and photo ID for us to file your insurance. If you do not have your card or proof of insurance at the time of your appointment, you will be expected to pay in full, 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 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. **All co-pays, deductibles, percentages, etc. are expected to be pay at the time of 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: We make every effort to answer all calls in person, however in the event we are unable to answer your call immediately, please provide the best number to reach you and your date of birth. All calls will be returned in 1-2 business days.

AFTER HOURS PROBLEMS: In case of an emergency, dial 911. You may call the office and leave a message. We are available only for urgent issues that can't wait for the office to open the next business day. All post-op patients will be given a way to reach the doctor if an emergency arises.

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____

Name of Guardian / Relationship (if applicable):____

PATIENT PORTAL For access to the patient portal contact the front desk for a User Name and Password

HAMBLIN
DERMATOLOGY

MEDICAL • SURGICAL • COSMETIC

Show Low Location 928.532.7546 - Safford Location 928.424.7546

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 name 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 name appears on Medicare card Date