DeVore Dermatology, P.A.

490 Floyd Road Spartanburg, SC 29307

PATIENT INFORMATION SHEET

DATE:_____ SOCIAL SECURITY #_____

Name _____

MAILING ADDRESS _____

CITY_____ STATE_____ ZIP _____

HOME PHONE #_____ WORK PHONE #_____ CELL PHONE # _____

Email Address: _____

SEX_____ DATE OF BIRTH_____ MARITAL STATUS _____

FAMILY DOCTOR/INTERNIST/PRIMARY CARE PHYSICIAN_____

REFERRED BY: _____

EMPLOYER_____ STUDENT: YES NO

IF PATIENT IS MARRIED, SPOUSE'S NAME _____ WORK# _____

IF PATIENT IS A CHILD, FATHER'S NAME _____ WORK# _____

MOTHER'S NAME_____ WORK# _____

Responsible Party

Name (FIRST, MI, LAST)_____

SOCIAL SECURTY #_____ D.O.B. _____

MAILING ADDRESS _____

CITY_____ STATE_____ ZIP_____

HOME PHONE #_____ WORK PHONE #_____ CELL PHONE #_____

OTHER INFORMATION

EMERGENCY CONTACT PERSON_____ RELATIONSHIP TO PATIENT_____

HOME PHONE #_____ CELL PHONE#_____ WORK PHONE #_____

INSURANCE INFORMATION

PRIMARY_____

GROUP#_____ POLICY#_____

POLICY HOLDER_____ DATE OF BIRTH_____ SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT_____ EMPLOYER_____

SECONDARY_____

GROUP#_____ POLICY#_____

POLICY HOLDER_____ DATE OF BIRTH_____ SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT_____ EMPLOYER_____

PLEASE COMPLETE MEDICAL HISTORY ON REVERSE SIDE

MEDICAL HISTORY

CHART # _____

Please **THOROUGHLY COMPLETE** this history form to help ensure the best possible medical treatment.

Patient: _____ Age: _____ Today's Date: _____

REASON FOR VISIT: _____

How long have you had this problem? _____

What treatment have you used on your own? _____

What prescription treatments have been used? _____

_____

Have you had **aspirin or ibuprofen** in the last two weeks? ❒ yes ❒ no

Have you ever had **dental anesthesia** (novocaine)? ❒ yes ❒ no

If yes, any bad reactions? _____

Do you smoke? ❒ yes ❒ no If yes, how much? _____

Do you drink alcohol? ❒ yes ❒ no If yes, how many drinks per day? _____

Do you use IV drugs? ❒ yes ❒ no If yes, what kind? _____

Have you ever had or been exposed to HIV (AIDS)? ❒ yes ❒ no

Have you had the COVID Vaccine & Booster? ❒ yes ❒ no Date: _____

Have you ever had or been exposed to Hepatitis? ❒ yes ❒ no

When you are exposed to the sun do you: ❒ Tan only ❒ Tan and Burn ❒ Burn

Have **you** ever had **skin cancer**? ❒ yes ❒ no

Skin Cancer History:

Basal cell carcinoma ❒ yes ❒ no Squamous cell carcinoma ❒ yes ❒ no Melanoma ❒ yes ❒ no

If Yes, year last skin cancer treated _____

Has a **family member** had **skin cancer**? ❒ yes ❒ no

If Yes, was it **melanoma**? ❒ yes ❒ no If yes, whom? _____

Do you have a history of any specific **skin diseases**? ❒ yes ❒ no ❒ Psoriasis ❒ Eczema

If Yes, please list type: _____

Do you have artificial joints? ❒ yes ❒ no

Do you bleed easily? ❒ yes ❒ no

Do you faint easily? ❒ yes ❒ no

(Women) Are you Pregnant? ❒ yes (due date) _____ ❒ no

What **blood relative** has:

Diabetes _____ Asthma _____ Hay fever _____

Skin disease _____ What type? _____

Do **you** have any of the following conditions?

Diabetes _____ Asthma _____ Hay fever _____ Heart disease _____

Lung disease _____ Stomach ulcers _____ High blood pressure _____

Are you under hospice care? ❒ yes ❒ no

I. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 864-596-7546 or by requesting one at the office.

_____ _____

Date Signature of Patient/Guardian Representative*

*If not the patient, please print your name and relationship to the patient: _____

DISCLOSURE TO OTHER PERSONS REGARDING YOUR HEALTH INFORMATION

(Please be aware that you may change this information at any time by requesting to complete a new form.)

This practice may disclose personal health information about you to your referring doctor, family doctor, family, close personal friends or any person that you identify, as long as the information disclosed to those individuals is relevant to their involvement in your care or the payment for your care. This practice may also notify a family member or another person who is responsible for your care of your location and general health condition.

_____I do not object to my personal health information being disclosed to a doctor, family member, friend or other individual involved in my care. Persons I authorize for disclosure: **(List specific names)** _____

_____

_____I object to my personal health information being disclosed to anyone other than myself.

II. LAB SERVICES

In the event that you have lab work done in this office, you may receive a bill for those services from another vendor.
A.) Pathology specimens will be sent to Celligent Diagnostics B.) Blood work will be sent to LabCorp
C.) I will be responsible for any amount insurance does not cover _____ _____

Patient or Guardian Signature Date

Read carefully before completing: If for insurance purposes pathology specimens or blood work need to be sent elsewhere please indicate where to send them below and notify the nurse at the time of the procedure. If at any time this information changes, it is the patients' responsibility to notify appropriate staff:

Pathology_____Blood work_____ Patient Signature_____

III. COSMETIC INTEREST

Please circle any cosmetic interests you would like to discuss with the doctor today.

Sclerotherapy (eliminates leg veins)

Smoothing Nasolabial Folds (smile lines)

Laser Hair Removal

Laser Removal of Vascular Lesions (blood vessels)

Microdermabrasion (exfoliates skin and cleanses pores)

Jane Iredale Mineral Makeup

Skin Care Products

Botox or Dysport (smooths frown lines)

Laser Skin Rejuvenation (treats fine lines and sun damaged skin, no down time, encourages collagen growth)

FINANCIAL AGREEMENT

Please Initial Each Line

1. _____ **We now request a debit, credit or health savings card on file for all accounts. Any amount the insurance states is your responsibility will be applied to the card on file. We do not send out bills for these balances. Use your EOB from your insurance company to show you what your responsibility would be.**
2. _____ **I understand that a copayment or coinsurance is required at the time of my visit.** Visa, MasterCard, Discover, and debit cards are accepted.
3. _____ All balances must be paid before buying products or cosmetic procedures.
4. _____ All balances due after insurance must be paid in 60 days unless a written arrangement has been made.
5. _____ I recognize that ultimate financial responsibility for my account remains mine. If my insurance company does not pay the practice within a reasonable period, I will be responsible for the payment. If DeVore Dermatology receives a check from my insurance company they will refund any overpayment in excess of $5.00. Overpayments under $5.00 will show as a credit on my account.
6. _____ I authorize DeVore Dermatology to file my insurance(s) as a courtesy to me and understand payment for these services will be mailed directly to this office.
7. _____ I understand that not all insurance plans cover all services. In the event my insurance plan determines a service to be "not covered" I will be responsible for the complete charge. I hereby guarantee payment in full of any and all charges for services rendered not covered by any health insurance plan, including all deductible and coinsurance amounts.
8. _____ As a courtesy to others and to avoid a $50.00 service charge, we kindly ask that you give a 2 business day cancellation notice. We realize emergencies do arise and we will handle those on a case by case basis.

_____	_____	_____
Patient Signature (or parent if a minor)	**Print Name**	**Date**

If you are not the patient, please state your relationship_____

MEDICARE PATIENTS ONLY:
STATEMENT TO ASSIGN MEDICARE BENEFITS TO PHYSICIAN OR SUPPLIER

Patient's Name:_____ Medicare Number:_____

"I request that payment of authorized Medicare Benefits be made on my behalf to DeVore Dermatology, P.A. for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services." Signature_____ Date_____

STATEMENT TO ASSIGN MEDIGAP BENEFITS TO PHYSICIAN OR SUPPLIER (SUPPLEMENTAL)

"I authorize Medicare to file my supplemental (Medigap) insurance. I request that payment be made to DeVore Dermatology, P.A. for any services furnished to me by that physician. I authorize the release of any medical information necessary to process this claim." Signature_____ Date_____

MEDICARE NON-COVERED SERVICES WAIVER

"I understand that there is a $10.00 charge for phoned in prescriptions (CPT 99371) and a $40.00 charge for missed appointments or appointments cancelled with less than a 2 business day notice. I am aware that these charges are not covered by Medicare and that I will be financially responsible for this charge if and when it is incurred.

Signature_____ Date _____ Witness _____

UNIVERSAL MEDICATION FORM

Birth Date: **Date form started:**

Name:

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	COVID 19 Vaccine / Booster
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

Allergic To / Describe Reaction:	**Allergic To / Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION/DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for taking / Doctor Name