PARAGON

SKIN & SURGERY

PATIENT DEMOGRAPHIC FORM

TODAY'S DATE: _____

Please complete this form to ensure proper billing of your services.

REQUIRED Social Security Number: _____ - _____ - _____

Name: _____ Date of Birth: _____
First Middle Last

Age: _____ Gender: _____ Email (for your patient portal): _____

Street Address: _____ City, State, Zip: _____

Preferred Phone #: _____ ☐ HOME ☐ MOBILE Alternate Phone #: _____ ☐ HOME ☐ MOBILE ☐ WORK

Emergency Contact Information

Emergency Contact Name: _____ Relationship to You: _____

Best Contact # for Emergencies: _____

Primary Care Information

Primary Care Physician: _____

Address (street): _____

City, State, Zip: _____

Telephone #: _____

Ref. Physician (if different): _____

Address (street): _____

City, State, Zip: _____

Telephone: _____

Insurance Information

Policy Holder's Name: _____

Your Relationship to Policy holder (or write SELF): _____

Policy Holder's Date of Birth: _____

PRIMARY Insurance Carrier: _____

Member ID #: _____

SECONDARY Insurance Carrier: _____

Member ID #: _____

Pharmacy Information

Pharmacy Name: _____ Select One: ☐ Local ☐ Mail Away

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

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Electronic Communications

Patient Portal: For your convenience, our practice offers secure electronic communications between you and your office via the Patient Portal. Secure messages and information can be read only by someone who knows your password to log in to the Portal site. The communications are automatically encrypted and, for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to participate using my email provided on Page 1.

☐ No, I do not wish to participate at this time and decline online access to my clinical notes, results, and the ability to exchange messages via the portal.

Appointment Reminders: As an added convenience, we offer appointment reminder phone calls and texts via an automated service. The reminders are sent using a software service and cannot be used as a way for you to communicate back to us. Should you need to reach us, please call our main number. If at any time you change your mind about reminders, please let us know or simply opt out by following the prompts in the voice calls or texts.

I understand under the Telephone Consumer Protection Act, that in order for the practice to contact me for services related to my medical care, Paragon Skin & Surgery and/or its agents may contact me by phone, including my cell phone, which may result in charges to me. Methods of contact may include prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

☐ Yes, I want to participate. Phone #: _____

☐ No, I do not wish to participate at this time and decline any reminders for my future appointments.

Patient Signature: _____ Date: _____

Additional Information

Which category best describes your racial background?

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unreported/Refuse to Report

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse: _____

Ethnicity: How would you describe your ethnicity, such as your family background or ancestry?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refuse to Report

Preferred language: What language do you usually speak at home?

☐ English ☐ Spanish ☐ Other _____

Whom can we thank for referring you to our practice?

☐ Health Insurance ☐ Social Media ☐ Google/Other Search Engine ☐ ER/Hospital/Doctor

☐ Newspaper/Magazine ☐ Other Patient _____ ☐ Other _____

HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS

We are required by law to maintain the privacy of protected health information and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. By signing below, patient acknowledges that he/she has been given the option of receiving a copy or been afforded an opportunity to review this Notice of Paragon Skin & Surgery HIPAA Notice of Privacy Practices.

Print Name	Patient Signature	DOB	Today's Date
_____	_____	_____	_____

Patient Contact Information

Preferred #: (Telephone) _____ Alternate #: (Telephone) _____

I authorize messages with medical information to be left on (check all that apply):

☐ Preferred # ☐ Alternate # ☐ Email

I authorize brief message details: ☐ Preferred # ☐ Alternate #

I authorize extended message details: ☐ Preferred # ☐ Alternate #

Restrictions/Instructions: _____

Release of Medical History, Treatment, and Billing Information

I authorize the following individual(s) to receive information regarding any medical history, treatment, billing issues and to act on my behalf:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Restrictions/Instructions:

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office. My revocation will be effective once received by Paragon Skin & Surgery
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name	Patient Signature	Date
_____	_____	_____

FINANCIAL POLICY

Thank you for choosing Paragon Skin & Surgery as your health care provider. We are committed to building a successful physician-patient relationship, and the success of your medical treatment and care. Your understanding of our Practice Financial Policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions. If you need further information or assistance about any of these policies, please ask to speak with our Practice Manager.

Authorization for Treatment and Payment of Medical Benefits
I give permission to Paragon Skin & Surgery to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

Use of Photography
I agree that any photo identification and photos of spot and lesion sites taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of my treatment and medical care.

e-Prescription Consent for Medication History
We may request and use your prescription medication history information from your pharmacy using our e−prescription feature. This is only for informational purposes so that an up−to−date record of your medication is available for your treatment and safety.

- ☐ Yes, I consent to obtain my medication history using the e−Prescribing feature.
- ☐ No, I do not consent. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian) understand that I am ultimately responsible for the payment of my treatment and care, including Lab/Pathology fees, which are separate from normal Practice fees.
- Paragon Skin & Surgery will assist me by billing my contracted insurers. However, I understand that I am required to provide the office with the most correct and updated information for my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated. I understand that if I need a referral, it is my responsibility to contact my primary doctor for the referral prior to my Paragon Skin & Cancer appointment. I understand that any bills resulting from not obtaining the required referral are my responsibility as the patient.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand payment is due at the time of service, payable by cash, check, and most major credit cards, including HSA and FSA cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include, but are not limited to:

  - Charge for returned checks
  - Charge for the copying and distribution of patient medical records
  - Charge for forms the practice fills out on your behalf
  - Charge for missed appointments

Patient Authorizations

I hereby authorize Paragon Skin & Surgery to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services. I hereby authorize assignment of financial benefits directly to Paragon Skin & Surgery I understand that I am financially responsible for charges not covered or denied, in full or in part, by my insurance plans.

Print Name:_____ Signature:_____ Date: _____

HEALTH HISTORY & INTAKE FORM

Name:

Past Medical Conditions:

NONE

- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cerebrovascular accident (Stroke)
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Elevated blood pressure
- ☐ End−stage renal disease
- ☐ Human immunodeficiency virus infection
- ☐ Hypercholesterolemia (High cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma (clinical)
- ☐ Malignant tumor of colon
- ☐ Radiation therapy treatment management
- ☐ Transplantation of bone marrow

☐ Other: _____

Past Surgical History:

NONE

- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ History of tissue graft heart valve replacement
- ☐ Hysterectomy
- ☐ Mechanical heart valve replacement Splenectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other: _____

Skin Disease History:

- ☐ NONE
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal cell carcinoma of skin
- ☐ Contact dermatitis due to poison ivy Dysplastic nevus of skin
- ☐ Eczema
- ☐ History of asthma
- ☐ Other: _____
- ☐ History of hay fever Malignant melanoma Pruritis of scalp
- ☐ Psoriasis
- ☐ Squamous cell carcinoma Sunburn of second degree

Review of Symptoms and Alerts

Do you currently experience or have any of the following? ***Check Yes or No for each.***

SYMPTOMS	YES	NO
Problem with bleeding	☐	☐
Problem with healing	☐	☐
Problem with scarring (hypertrophic or keloid)	☐	☐
Changing mole	☐	☐
Rash	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Fever or chill	☐	☐
Headache	☐	☐
Hay fever	☐	☐
Joint aches	☐	☐
Muscle weakness	☐	☐
Neck stiffness	☐	☐
Thyroid problem	☐	☐
Unintentional weight loss	☐	☐

ALERTS	YES	NO
Pacemaker	☐	☐
Defibrillator	☐	☐
Artificial joints within past 2 years	☐	☐
Artificial heart valve	☐	☐
Premedication prior to procedure	☐	☐
Allergy to adhesive	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Blood thinners	☐	☐
Pregnancy or planning a pregnancy	☐	☐
Allergy to lidocaine	☐	☐
Rapid heartbeats with epinephrine	☐	☐
Yeast infections with antibiotics	☐	☐
GI upset with antibiotics	☐	☐
Carbocaine only	☐	☐

SKINCARE & MEDICATIONS INFORMATION

Name:

Reason for today's visit: _____

Skincare Questionnaire

Do you wear sunscreen regularly? ☐ Yes, I use SPF _____ ☐ Not Currently

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes _____ ☐ No

Are you currently taking any medications? ☐ Yes, see below ☐ NONE

Name of Medication (include all over–the–counter & herbal supplements)	Dose (mg, mcg, tablet, etc.)	Frequency (1x day, 2x day, 1x wk, as needed, etc.)	Last Time Taken

Allergies to the following medications:

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

***Smoking & Alcohol History*:**

Cigarette smoking: ☐ Never smoked ☐ Quit – former smoker ☐ Less than once/day ☐ Daily

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Alcohol use: ☐ Non–drinker ☐ Fewer than once/day ☐ 1–2 drinks ☐ 3+ drinks/day

How many times *in the past year* have you had 5 or more drinks (for men), or 4 or more drinks (for women/adults over 65)? _____

Illicit drug use: ☐ Never used ☐ IV drug use ☐ Other

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_____ _____
Patient's Name (please print) Patient's Date of Birth

Please answer the following questions to the best of your ability.
This is so our office is in compliance with insurance guidelines set by the Federal Government.

1. Do you currently smoke cigarettes or use smokeless tobacco?

☐ YES ☐ NO ☐ FORMER SMOKER (QUIT DATE: _____)

2. If you answered YES to Question #1, are you aware of resources available to help you quit smoking?

☐ YES ☐ NO ☐ I WISH TO RECEIVE INFORMATION

3. Did you receive the flu vaccine this season?

☐ YES ☐ NO

4. Patients 65 years of age and older:
   - Do you have a healthcare proxy in the event you are unable to make your own medical decisions?

☐ YES ☐ NO

If you answered yes, please list their name & telephone number:

_____ _____

- Do you have a living will/advanced directive?

☐ YES ☐ NO

- Have you had your pneumonia vaccination on or after your 60th birthday?

☐ YES ☐ NO

5. Patient's ages 13-18 years of age:

Did you receive one dose of meningococcal (meningitis) vaccine on or between your 11th & 13th birthdays?

☐ YES ☐ NO

Did you receive one tDap vaccine on or between your 10th & 13th birthdays

☐ YES ☐ NO

Have you had at least 3 HPV vaccines on or between your 9th & 13th birthdays?

☐ YES ☐ NO

6. **DO NOT INTUBATE:**

☐ I do not wish to have a breathing tube placed, even if it's necessary to save my life.

7. **DO NOT RESUSCITATE:**

☐ If my heart were to stop, I do not wish to have chest compressions or use of a defibrillator to restart my heart, even if it it's necessary to save my life.

8. **FULL CARDIOPULMONARY RESUSCITATION**

☐ I want full cardiopulmonary resuscitation efforts to be made if my heart or breathing stops.

Signature: _____ Date: _____