TODAY'S DATE_____

PATIENT INFORMATION

NAME_____
LAST FIRST MI SUFFIX NICKNAME

MARITAL STATUS (circle one) SINGLE MARRIED WIDOWED DIVORCED OTHER

SOCIAL SECURITY #_____DATE OF BIRTH_____AGE_____

SEX_____PREFERRED LANGUAGE_____

ETHNIC GROUP (circle one) HISPANIC OR LATINO NOT HISPANIC OR LATINO UNKNOWN

RACE (circle one)

AMERICAN INDIAN/ALASKA NATIVE ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER WHITE OTHER

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED_____PHONE #_____

CONTACT INFORMATION

PATIENT HOME PHONE#_____PT. WORK PHONE#_____PT. CELL #_____

E MAIL ADDRESS_____

PATIENT ADDRESS_____
STREET APT# CITY STATE ZIP

PATIENT'S EMPLOYER_____ (or circle one) FT STUDENT PT STUDENT RETIRED UNEMPLOYED

NAME OF RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT

RESPONSIBLE PARTY NAME_____ DATE OF BIRTH _____

MAILING ADDRESS OF RESPONSIBLE PARTY_____
STREET APT# CITY STATE ZIP

RESPONSIBLE PARTY HOME PHONE #_____ WORK PHONE#_____ CELL PHONE#_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME_____

NAME OF INSURED_____

PT. RELATIONSHIP TO INSURED_____

INSURED DOB_____INSURED SS#_____

SECONDARY INSURANCE NAME_____

NAME OF INSURED_____

PT. RELATIONSHIP TO INSURED_____

INSURED DOB_____ INSURED SS#_____

PRIMARY CARE PHYSICIAN_____LOCATION_____PHONE#_____

PHARMACY NAME_____LOCATION_____PHONE#_____

WHO REFERRED YOU TO OUR PRACTICE, IF NOT YOUR PHYSICIAN_____

PATIENT AUTHORIZATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the provider. I understand that I am responsible for notifying the office 24 hours in advance to cancel an appointment, otherwise I will be billed a $25 NO SHOW fee.

Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments, co-insurance and deductibles will be expected to be collected PRIOR to seeing the provider. If your check does not clear the bank, a $25 service fee will automatically be added to your account. Understand any procedure performed in the office may be billed separately in addition to the office visit fee. Any request by the patient for copies of their medical record will incur a handling and copying fee within the Illinois statute. A $50 deposit will be required in advance for all cosmetic procedures, and forfeited if the appointment is not cancelled 24 hours in advance.

My signature below signifies my understanding and willingness to comply with the above policies.

Patient/Parent or Responsible party signature_____ Date:_____

PATIENT NAME: _____ HEALTH HISTORY page 1
(PLEASE PRINT)

PAST MEDICAL HISTORY: Please ✔ all that apply ☐ NONE

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fib. (Irregular Heart)
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Other:_____

PAST SURGICAL HISTORY: Please ✔ all that apply ☐ NONE

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast : Breast Biopsy
- ☐ Breast : Lumpectomy (Both Breasts)
- ☐ Breast : Lumpectomy (Left Breast)
- ☐ Breast : Lumpectomy (Right Breast)
- ☐ Breast : Mastectomy (Both Breasts)
- ☐ Breast : Mastectomy (Left Breast)
- ☐ Breast : Mastectomy (Right Breast)
- ☐ Colon (Colectomy) : Colon Cancer Resection
- ☐ Colon (Colectomy) : Diverticulitis
- ☐ Colon (Colectomy) : Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart : Biological Valve Replacement
- ☐ Heart : Coronary Artery Bypass Surgery
- ☐ Heart : Heart Transplant
- ☐ Heart : Mechanical Valve Replacement
- ☐ Heart : PTCA
- ☐ Joint Replacement : Hip (Both)
- ☐ Joint Replacement : Hip (Left)
- ☐ Joint Replacement : Hip (Right)
- ☐ Joint Replacement : Knee (Both)
- ☐ Joint Replacement : Knee (Left)
- ☐ Joint Replacement : Knee (Right)
- ☐ Kidney : Kidney Biopsy
- ☐ Kidney : Kidney Stone Removal
- ☐ Kidney : Kidney Transplant
- ☐ Kidney : Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy) : Endometriosis
- ☐ Ovaries (Oophorectomy) : Ovarian Cancer
- ☐ Ovaries (Oophorectomy) : Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate : Prostate Biopsy
- ☐ Prostate : Prostatectomy
- ☐ Prostate : TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy) : Fibroids
- ☐ Uterus (Hysterectomy) : Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer

Other:_____

SKIN DISEASE HISTORY: Please ✔ check all that apply

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Dysplastic Nevi/Atypical moles

OTHER:_____

SKIN DISEASE HISTORY: Please ✔ check all that apply

☐ Do you wear Sunscreen
If yes, what SPF_____

☐ Do you use tanning bed
☐ Did you use tanning beds in the past

☐ Do you have a family history of melanoma
If yes, which relative
_____

MEDICATIONS: Please list all your current medications including non-prescription over-the-counter and supplements or attach a copy of your medication list

Medication	Dose	Frequency	Medication	Dose	Frequency	Medication	Dose	Frequency

ALLERGIES:

_____ _____ _____ _____

_____ _____ _____ _____

SOCIAL HISTORY: Please ✔ check all that apply

☐ No Alcohol
☐ Less than one drink per day
☐ 1-2 drinks per day
☐ 3 or more drinks per day
☐ Street Drug use
☐ Smokes cigarettes daily
☐ Smokes occasionally
☐ Former smoker
☐ Never smoked

Other_____

REVIEW OF SYSTEMS: Are you currently experiencing or have any of the following Please check ✓ all that apply

☐ Problems with bleeding
☐ Problems with healing
☐ Problems with scarring
☐ Immunosuppression
☐ Changing mole
☐ Rash
☐ Stomach pain
☐ Anxiety
☐ Blood in stool
☐ Blood in urine
☐ Blurry vision
☐ Chest pain
☐ Cough
☐ Depression
☐ Fever or Chills
☐ Headaches
☐ Hay Fever
☐ Joint aches
☐ Muscle Weakness
☐ Neck Stiffness
☐ Night sweats
☐ Seizures
☐ Shortness of breath
☐ Sore throat
☐ Thyroid problems
☐ Unintentional weight loss
☐ Wheezing

OTHER:_____

ALERTS: Please ✔ check all that apply

☐ Pacemaker
☐ Defibrillator
☐ Artificial joint last 2 yrs
☐ Artificial heart valve
☐ Antibiotics needed prior to procedure
☐ Allergy to adhesives
☐ Allergy to topical antibiotic ointment
☐ Blood thinners
☐ Pregnant or plannin a pregnancy
☐ Breast feeding
☐ Allergy Lidocaine
☐ Rapid heart beat with epinephrine
☐ Yeast infection with antibiotic
☐ Stomach upset w/ antibiotic

_____ _____
Patient Signature Date

MD | MOORE DERMATOLOGY ASSOCIATES

AUTHORIZATION/FINANCIAL AGREEMENT

I authorize the release of medical information to my primary care physician, referring physician, or consulting physician, needed to process insurance claims, insurance application and prescriptions.

I authorize payment of medical benefits for services rendered to the provider.

I authorize the use of this signature on all insurance submissions.

I understand that payment is required for all services at the time they are rendered unless I am in an insurance plan in which the practice participates. For those patients, I understand that my insurance will be billed for today's service. However, any copays due will be collected prior to seeing the provider. I understand that I am fully financially responsible for all charges not covered or denied by my insurance plan. Payment is expected within 30 days of the date of service. If payment is not received within 30 days of the date of service, a service charge may be applied.

I understand that payment is expected and appreciated at the time of service. Failure to pay the bill, will result in additional fees for collection agency or attorney costs. **The doctors reserve the right to refuse to see a patient whose account has been sent to collections for non-payment. In order for the doctors to see the patient, the patient must pay their past due amount to the collections company that currently holds their account.** We appreciate your understanding.

I understand that if my account is turned over to collections for non-payment, an additional **$30.00 collection fee** will be added to my account.

I understand there will be a **$25.00 fee** charged for checks returned for insufficient funds.

I understand any procedure performed in the office may be billed separately in addition to the office visit fee.

I understand that any request by the patient for copies of medical records will incur a handling & copying fee within the Illinois statute.

I authorize (by supplying my home phone number, mobile phone number, email address and any other personal contact information) my health care provider to employ a third-party automated-outreach-program to use the name of my dermatology care provider, the time and place of my scheduled appointment and other limited information for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam or balance due.

I consent to the receiving of an email reminder of my appointment, a text message reminder of my appointment and a message about my appointment being left on my voicemail, answering machine or with another individual, if I am unavailable at the number provided by me. This will only be notification of the provider, day, time and location of your appointment. No other information, such as what the appointment is for, will be given out.

I authorize and give my permission to receive emails and/or mailing specials from Moore Dermatology.

I understand that I am responsible for notifying the office 24 hours in advance to cancel an appointment. Otherwise, I will be responsible and billed for a **$25.00 No Show Fee.**

I understand that there may be an out of pocket fee if the doctors/physician assistant are paged after hours, and if a response is required by the doctor/physician assistant to an email or text, and for a refill of a medication if the patient has not been seen recently.

I acknowledge that I have been offered and reviewed this office's Notice of Privacy Practices (HIPAA).

Patient Name (please print): _____

Patient Signature (for patients age 18 or over): _____Date: _____

Signature of Parent/Guardian/Legal Representative: _____ Date: _____

MOORE DERMATOLOGY ASSOCIATES

PRIVACY PRACTICES NOTICE ACKNOWLEDGEMENT FORM & REQUEST FOR CONFIDENTIAL COMMUNICATION

My signature below, acknowledges that the medical practice of Moore Dermatology has provided a Privacy Practices Notice to me (posted in waiting room). I also acknowledge that the Privacy Practices Notice adequately describes how this medical practice assures the safety of my protected health information, and adequately explains my rights to privacy regarding the medical care I am seeking. I understand Moore Dermatology has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available

I request Moore Dermatology to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

PATIENT PHONE NUMBERS (please list)	**TYPE (please circle)**	**LEAVE DETAILED MESSAGE**	**LEAVE DETAILED LAB/TEST RESULTS**
PRIMARY PHONE NUMBER:	HOME WORK CELL	YES NO	YES NO
SECONDARY PHONE NUMBER:	HOME WORK CELL	YES NO	YES NO

CORRESPONDENCE (please list)	**DETAILED TEST/LAB RESULTS**	**BILLING**	**APPOINTMENT REMINDERS**	**PROMOTIONAL SPECIALS**
PATIENT MAILING ADDRESS:	YES NO	YES NO	YES NO	YES NO
PATIENT EMAIL ADDRESS:	YES NO	YES NO	YES NO	YES NO

By signing this authorization form, you are allowing Moore Dermatology to share your health information with the family and friends whom you **list below** and who may be involved in your care or payment for your care.
I give permission for Moore Dermatology to share (either verbally, in writing, by phone, voice mail or email) my health information to the following individuals for purposes of my care and/or payment for care.

NAME	**PHONE NUMBER**	**RELATIONSHIP**

(I have the right to withdraw (take back) this authorization at any time. My withdrawal must be in writing. Any withdrawal will not apply to information already released by Moore Dermatology prior to my withdrawal. Written withdrawal of this consent must be sent to the physician's office).

Patient Name (please print) _____

Patient Signature (for patients age 18 or over): _____Date: _____

Signature of Parent/Guardian/Legal Representative: _____Date: _____

501 W. North Avenue, Suite 103
Melrose Park, IL 60160
708 450-5086 phone
708 345-4075 fax

Julie Anne Moore, M.D., FAAD
Kelly L. Abate, M.D., FAAD
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