

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 _____

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 _____

RESPONSIBLE PARTY HOME PHONE # _____ STREET APT# CITY WORK PHONE# STATE ZIP CELL PHONE#

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____ SECONDARY INSURANCE NAME _____

NAME OF INSURED _____ NAME OF INSURED _____

PT. RELATIONSHIP TO INSURED _____ PT. RELATIONSHIP TO INSURED _____

INSURED DOB _____ INSURED SS# _____ 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: _____
(PLEASE PRINT)

PAST MEDICAL HISTORY: Please ✓ all that apply NONE

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

Other: _____

PAST SURGICAL HISTORY: Please ✓ all that apply NONE

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

Other: _____

SKIN DISEASE HISTORY: Please ✓ check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Dysplastic Nevi/Atypical moles |

OTHER: _____

SKIN DISEASE HISTORY: Please ✓ check all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Do you wear Sunscreen | <input type="checkbox"/> Do you use tanning bed | <input type="checkbox"/> Do you have a family history of melanoma |
| | <input type="checkbox"/> Did you use tanning beds | If yes, which relative |
| If yes, what SPF _____ | in the past | _____ |

PATIENT NAME: _____
(PLEASE PRINT)

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
- 1-2 drinks per day
- Street Drug use
- Smokes occasionally
- Less than one drink per day
- 3 or more drinks per day
- Smokes cigarettes daily
- 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
- Anxiety
- Fever or Chills
- Seizures
- Problems with healing
- Blood in stool
- Headaches
- Shortness of breath
- Problems with scarring
- Blood in urine
- Hay Fever
- Sore throat
- Immunosuppression
- Blurry vision
- Joint aches
- Thyroid problems
- Changing mole
- Chest pain
- Muscle Weakness
- Unintentional weight loss
- Rash
- Cough
- Neck Stiffness
- Wheezing
- Stomach pain
- Depression
- Night sweats

OTHER: _____

ALERTS: Please ✓ check all that apply

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

Patient Signature _____ Date _____



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. In that instance, 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 Associates.

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 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/or a response is required by the doctor/physician assistant to an email, text and/or 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: _____

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
Tracy M. Campbell, M.D., FAAD
Michaela Reinhart, PA-C



PRIVACY PRACTICES NOTICE ACKNOWLEDGEMENT FORM & REQUEST FOR CONFIDENTIAL COMMUNICATION

My signature below, acknowledges that the medical practice of Moore Dermatology Associates has provided a "Privacy Practices Notice" to me posted in the waiting room and on the website. 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 Associates 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 Associates 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	
	HOME	WORK	CELL	YES	NO	YES	NO
PRIMARY PHONE NUMBER:							
SECONDARY PHONE NUMBER:							

CORRESPONDENCE (please list)	DETAILED TEST/LAB RESULTS		BILLING		APPOINTMENT REMINDERS		PROMOTIONAL SPECIALS	
	YES	NO	YES	NO	YES	NO	YES	NO
PATIENT MAILING ADDRESS (include: City, State, ZIP Code)								
PATIENT EMAIL ADDRESS:								

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

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