MONTGOMERY
md DERMATOLOGY

Medical History

Date________________

Name____ DOB________________
(Last) (First) (MI)

Preferred Pharmacy: __________________ Location__________________Phone ___________

Primary Care Physician ____________________ Referring Physician ____________________

Medical History (If none, please circle NONE)

Artificial Joint	Diabetes	HIV/AIDS
Arthritis	Heart Attack	Liver Problems
Asthma	Heart Surgery	Lung Problems
Blood Disorder	Heart Pacemaker	Kidney Disease
__________ Cancer	Heart Valve Problems	__________ Transplant
Circulation Problems	Hepatitis	Tuberculosis
Colon Problems	High Blood Pressure	**NONE**

Other Health Problems:

____

____

Prior Surgeries: **NONE**

____

____

Current Medications (Please List Over the Counter Medications also):

____

____

____

Drug Allergies: **NONE**

____

____

Do you take a daily aspirin or blood thinner? **Yes** **No**

Do you require an antibiotic prior to surgeries? **Yes** **No**

Do you use Tobacco Products? **Yes** **No** If yes, what type and how often? ______________

Do you drink Alcohol? **Yes** **No** If yes, how many drinks per week? ______________

Do you wear Sunscreen daily? **Yes** **No** If yes, what SPF? __________

Do you have a history of Tanning Bed use? **Yes** **No** If yes, how often?______________

Do you have a family history of Skin Cancer? **Yes** **No**

If yes, who? ____

Have any family members been seen at Montgomery Dermatology? ______________________

MONTGOMERY md DERMATOLOGY

Demographics

Date________________

Name____ Nickname____________

(Last) (First) (MI)

DOB:____/_____/________ (MM) (DD) (YYYY) **Age:**______ **SSN**_____-_____-_______ **Sex:** Male Female

Marital Status: ____________________ **Email** ______________________________

Mailing Address: ____ (Apt#)

____

(City) (State) (Zip)

Phone Number: (H)________________ (W)________________ (C)________________

Which phone number would you prefer us to contact you on? ________________

May we leave detailed voicemails regarding your protected health information? Yes No

Employer:______________________ **Occupation:**______________________

Employer Address:____

____

(City) (State) (Zip)

Who may we speak with regarding your Protected Health Information?

Name________________________ Phone______________ Relationship ______________

Name________________________ Phone______________ Relationship ______________

Name________________________ Phone______________ Relationship ______________

OR ☐ We may not speak with anyone but you regarding your Protected Health Information.

In case of Emergency, who should we contact?

Name________________________ Phone ______________Relationship______________

Name________________________ Phone ______________Relationship______________

Insurance Information **(If other than patient)**

Primary Insurance____________________ Policy Holder's Name ____________________

Policy Holder's DOB____________________ Policy Holder's SSN____________________

Relationship to Patient ________________

Address if different than above: ______________________________________

Secondary Insurance____________________ Policy Holder's Name ____________________

Policy Holder's DOB____________________ Policy Holder's SSN____________________

Relationship to Patient ________________

Address if different than above: ______________________________________

Tricare Sponsor Name:____________________ Sponsor SSN____________________

Do you have a Prescription Coverage Card? ______________________________

Does your insurance require the use of a Specific Pharmacy? ______________________

Financial Agreement

Date_______________

Please initial each section below to indicate you understand and agree to the information:

______ **ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY**
I do, hereby, authorize payment ofall insurance benefits, basic and major medical, for the services I receive, to be made directly to Montgomery Dermatology. Regardless ofinsurance benefits, I agree all incurred cost is a legal and lawful debt. I understand that I am ultimately responsible for any and all unpaid balance or non-covered service. I agree to pay any/all collection agency fees, (33.33%), attorney fees, and/or court cost, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

______ **STATEMENT TO PERMIT MEDICARE BENEFITS TO PROVIDER AND PATIENT**
I request that payment ofauthorized Medicare or other applicable private insurance benefits be paid directly to Montgomery Dermatology for services provided under their care. I also authorize Montgomery Dermatology to release necessary medical information to my insurance company, its agents, or anythird party in order to determine payable benefits for theservices rendered.

______ **CONSENT FORMEDICAL SERVICES**
I authorize Montgomery Dermatology to render treatment to me/my dependents for dermatological care/medical procedures asmay be deemed necessary. I realize that in some circumstances, some insurance companies will not pay for certain procedures.

______ **REFERRALS/AUTHORIZATIONS**
I understand that ifmy insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. IfI do not have a referral at the time ofservice, no services will be rendered until I obtain a referral or pay for my visit in full before seeing the Provider.

______ **PRIVACY POLICY NOTICE**
A copy ofMontgomery Dermatology NoticeofPrivacy Policies can be locatedon our website, montgomerydermatology.com. In addition, a physical copy may be requested atany time detailing how my information may be used and disclosed aspermitted underfederal and state law.

______ **CONSENTFORLAB SERVICES**
Montgomery Dermatology contracts with an external lab to process biopsy specimens. It is my responsibility to ensure that these lab services are in network with my insurance company. Ifthe lab isoutofnetwork, I willnotify Montgomery Dermatology in advance. I am responsible for any outof network feesassociated withlab processing ifI havenotmadearrangements in advance with Montgomery Dermatology.

______________________________ Patient Name Print

______________________________ Patient D.O.B

______________________________ Patient or Legal Guardian Signature

______________________________ Date

______________________________ Legal Guardian Name Print

Express Prior Consent to Contact by Cell Phone

You agree, in order for us to service your account or to collect monies you may owe, Montgomery Dermatology, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device as applicable.

I/We have read the disclosure and agree that Montgomery Dermatology, PC, its employees and/or agents may contact me/us as described above.

______________________________ ______________

Patient name (PRINT) DOB

______________________________ ______________

Patient or Responsible Party Signature Date