MONTGOMERY
DERMATOLOGY

Demographics

Date_______________

Name____ Nickname___________
(Last) (First) (MI)

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

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)

Insurance Information

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? ________________________

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______________

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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? ________________________

**************************************To be Completed by Staff**

Updated:____

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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 of all insurance benefits, basic and major medical, for the services I receive, to be made directly to Montgomery Dermatology. Regardless of insurance 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 all costs of collecting, securing, or attempting to collect or secure payment, including reasonable attorney fees, court cost, or collection agency fees.

______ STATEMENT TO PERMIT MEDICARE BENEFITS TO PROVIDER AND PATIENT
I request that payment of authorized 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 any third party in order to determine payable benefits for the services rendered.

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

______ REFERRALS/AUTHORIZATIONS
I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, 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 of Montgomery Dermatology Notice of Privacy Policies can be located on our website, montgomerydermatology.com. In addition, a physical copy may be requested at any time detailing how my information may be used and disclosed as permitted under federal and state law.

______ CONSENT FOR LAB 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. If the lab is out of network, I will notify Montgomery Dermatology in advance. I am responsible for any out of network fees associated with lab processing if I have not made arrangements in advance with Montgomery Dermatology.

______________________________ ______________________
Patient Name Print Patient D.O.B

______________________________ ______________________
Patient or Legal Guardian Signature Date

____
Legal Guardian Name Print