General Patient Information

Last Name _____ First Name _____ Middle _____ Nickname _____

Marital Status _____ Driver's License _____ Social Security Number _____

Date of Birth _____ Age _____ Gender _____

Emergency Contact _____ Relationship _____ Emergency Phone Number _____

Patient Home Phone Number _____ Patient Cell Number _____ Preferred Phone _____

Is it ok to leave a message? Yes or No

Email Address _____ Would you like to opt in to email appointment notifications? Yes or No?

Home Address _____ City _____ State _____ Zip _____

Employer's Name _____ Occupation _____

If Patient is a Minor

Father's Last Name _____ First Name _____ Middle _____

Home Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Number _____ Preferred Phone _____

Mother's Last Name _____ First Name _____ Middle _____

Home Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Number _____ Preferred Phone _____

{ } Lives with both parents. { } Lives with Mother. { } Lives with Father. { } Other _____

Person Responsible for Payment on Account _____ His / Her SS# _____

I Authorize Great Plains Dermatology, P.A. to treat my minor patient _____

Signature

Insurance

{ } Self Paying Patient { } Active Insurance

_____ _____ _____

Insurance Company Name Policy Number Group Number

_____ _____ _____

Policy Holder's Last Name First Name Middle

_____ _____ _____

Policy Holder's Date of Birth Gender Patient's Relationship to Policy Holder

{ } Policy Holder's Home Address Same as Patient

_____ _____ _____ _____

Policy Holder's Home Address (If different than patient's) City State Zip

To Be Completed For All Medicare Patients

- Are you a veteran? { } Yes { } No
- Did the V.A. refer you here for treatment? { } Yes { } No
- Do you have a V.A. "fee basis ID card"? { } Yes { } No
- Do you have a Federal Black Lung Card? { } Yes { } No
- Is this medical condition due to an accident of any kind? { } Yes { } No
- If yes, was it: work related? _____ auto related _____
- Are you covered by any employer's health insurance plan through your own employment or that of a family member? { } Yes { } No

ONE TIME AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO ME OR ON MY BEHALF TO GREAT PLAINS DERMATOLOGY, P.A. FOR ANY SERVICES FURNISHED ME BY THEIR PHYSICIAN. I AUTHORIZE ANY HOLDER OR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

_____ _____

Patient Signature Date Signed

- I verify all information is correct and to the best of knowledge
- I hereby authorize Great Plains Dermatology, P.A. to furnish information to insurance carriers concerning my illness and treatments.
- I understand that claims will be submitted to contracting insurance companies and other electronic carriers, and that I am responsible for any amounts not covered by them.
- For commercial insurances, I understand that I am responsible for payment of services, either by cash, check, Discover, Mastercard, or Visa, on the day of services.
- If I am unable to pay the entire amount, I understand that I may request setting up a payment plan PRIOR to seeing the doctor.
- Insurance Information will be provided to me so that I may submit claims to my insurance company.

_____ _____

Patient Signature Date Signed

If you are a new patient, list your reason for seeing the doctor today _____

_____

_____

_____	_____
Preferred Pharmacy	City/State
_____	_____
Family Physician	City/State
_____	_____
Referring Physician	City/State

Skin Disease History: (please circle all that apply)

None	Basal Cell Carcinoma	Malignant Melanoma
Acne	Contact Dermatitis from Poison Ivy	Pruritus of scalp
Actinic Keratosis	Hay Fever	Psoriasis
Asteatosis Cutis	Dysplastic Nevus of skin	Squamous Cell Carcinoma
Asthma	Eczema	Sunburn of Second Degree

Other: _____

Do you wear sunscreen? { } Yes { } No If Yes, what SPF?

Do you tan in a tanning salon? { } Yes { } No

Family History:

Do you have a family history of Melanoma? { } Yes { } No. If Yes, which relative(s):

Mother	Sister	Daughter	Aunt	Grandmother	Cousin
Father	Brother	Son	Uncle	Grandfather	

History and Intake Form

Past Medical History: (please circle all that apply)

None	Diabetes mellitus	Inflammatory disease of liver
Anxiety disorder	Elevated blood pressure	Leukemia
Arthritis	End stage renal disease	Malignant Lymphoma
Asthma	Epilepsy	Malignant tumor of Lung
Atrial fibrillation	GERD	Malignant tumor of breast
Benign prostatic hyperplasia	Hypertension	Malignant tumor of color
Cerebrovascular accident	Hearing Loss	Malignant tumor of Prostate
Chronic obstructive lung disease	HIV	Radiation Therapy Treatment
Coronary arteriosclerosis	Hypercholesterolemia	Transplantation of Bone Marrow
Depressive disorder	Hyperthyroidism	Leukemia

Other: _____

Past Surgical History: (please circle all that apply)

- None
- Abdominoperineal Resection
- Appendectomy
- Bilateral knee replacement
- Biopsy of breast
- Breast Implants
- Biopsy of prostate
- Cholecystectomy
- Colectomy
- Colostomy
- Coronary artery bypass
- Entire transplanted kidney
- Excision of Basal Cell Carcinoma
- Excision of melanoma
- Excision of Squamous Cell Carcinoma
- Heart Transplant
- Hysterectomy
- Kidney Biopsy
- Kidney Stone Removal
- Liver Excision
- Liver Transplant
- Low Anterior Resection of Rectum
- Lumpectomy of Left Breast
- Lumpectomy of Right Breast
- Mastectomy Bilaterally
- Mastectomy of Left Breast
- Mastectomy of Right Breast
- Mechanical Heart Valve Replacement
- Oophorectomy
- Pancreatectomy
- Percutaneous Transluminal Coronary Angioplasty
- Portosystemic Shunt Operation
- Prostatectomy
- Prosthetic Arthroplasty of Bilateral Hips
- Splenectomy
- Tissue Graft Heart Valve Replacement
- Total Cystectomy
- Total Nephrectomy
- Total Orchidectomy
- Total Replacement of Left Hip
- Total Replacement of Right Hip
- Total Replacement of Left Knee
- Total Replacement of Right Knee
- Transurethral Prostatectomy
- Tubal ligation

Other: _____

Medications: (please list all current medications)

_____

_____

_____

_____

Allergies to medications: { } Yes { } No (If Yes, please list)

_____

_____

_____

_____

Latex Allergy: { } Yes { } No

Social History: (please circle all that apply)

Current Smoker Former Smoker
Never Smoked Drug Use