

## General Patient Information

\_\_\_\_\_  
Last Name First Name Middle Preferred Name

\_\_\_\_\_  
Marital Status Driver's License Social Security Number

\_\_\_\_\_  
Date of Birth Age Gender

\_\_\_\_\_  
Patient Home Phone Number Patient Cell Number Preferred Phone

Is it ok to leave a message? Yes or No

\_\_\_\_\_  
Would you like to opt in to email appointment notifications? Yes or No

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Home Address City State Zip

\_\_\_\_\_  
Employer's Name Occupation

\_\_\_\_\_  
Emergency Contact Relationship Emergency Phone Number

### 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 Responsible party SS#

I authorize Great Plains Dermatology, P.A. to treat my minor patient. \_\_\_\_\_  
Signature

### Authorization to Disclose Protected Health Information

I disclose Protected Health Information to the authorized parties listed below:

\_\_\_\_\_  
Name Phone Number Relationship to Patient

\_\_\_\_\_  
Name Phone Number Relationship to Patient

## Insurance

{ } Self Paying Patient

{ } Active Insurance

\_\_\_\_\_  
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 (If different than patient's)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**\*\*Please bring the patient's current insurance card and valid ID to the front desk at check-in. The patient's insurance card and ID will be scanned into the system at that time.\*\***

- I verify all information is correct and to the best of knowledge.
- I understand that I am financially responsible for charges for services rendered on my behalf or on behalf of my dependents.
- Great Plains Dermatology, P.A. is allowed by contract with your insurance company to collect copays, coinsurance, and unmet deductible at the time of service. Payment is required at the time of service, and the amount collected is estimated based on benefit information available.
- I understand that if I have a surgical procedure or biopsy performed that requires further examination by a pathologist, there are three separate charges that will occur, as required by my health insurance plan: (1) a charge by my treating provider for collecting the specimen; (2) a charge by the pathologist or medical doctor to examine the specimen; and (3) a charge by the laboratory preparing the specimen for the pathologist. I understand that I will be billed separately by my provider, the pathologist, and the laboratory.
- I understand that my insurance company may have a preferred lab for specimens or blood work. It is my responsibility to know which preferred lab I can use, and to inform my provider at the time of service.
- I hereby authorize Great Plains Dermatology, P.A. to furnish information to insurance carriers concerning my illness and treatments.
- Insurance coverage is not a guarantee of payment. I understand that I am responsible for any remaining balance not covered by my insurance company. It is my responsibility to contact them if I have questions regarding my benefits and coverage.

By signing below, I certify that I have read the above information and certify my understanding and agreement with the above information. The duration of this consent is indefinite and continues until revoked in writing.

\_\_\_\_\_  
Patient/Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Preferred Pharmacy

\_\_\_\_\_  
City/State

\_\_\_\_\_  
Family Physician

\_\_\_\_\_  
City/State

\_\_\_\_\_  
Referring Physician

\_\_\_\_\_  
City/State

If you are a new patient, list your reason for seeing the provider today.

### History and Intake

**Past Medical History:** (please circle all that apply)

<p><b>None</b></p> <p>Anxiety disorder</p> <p>Arthritis</p> <p>Asthma</p> <p>Atrial fibrillation</p> <p>COVID-19</p> <p>Cerebrovascular accident</p> <p>Chronic obstructive lung disease</p> <p>Coronary arteriosclerosis</p> <p>Depressive disorder</p> <p>SARS-CoV-2 mRNA Vaccine</p>	<p>Diabetes mellitus</p> <p>Elevated blood pressure</p> <p>End stage renal disease</p> <p>Epilepsy</p> <p>GERD</p> <p>Hypertension</p> <p>Hearing Loss</p> <p>HIV</p> <p>Hypercholesterolemia</p> <p>Hyperthyroidism</p> <p>Other: _____</p>	<p>Hypothyroidism</p> <p>Inflammatory disease of liver</p> <p>Leukemia</p> <p>Malignant Lymphoma</p> <p>Malignant tumor of breast</p> <p>Malignant tumor of colon</p> <p>Malignant tumor of lung</p> <p>Malignant tumor of prostate</p> <p>Radiation Therapy Treatment</p> <p>Transplantation of Bone Marrow</p>
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**Past Surgical History:** (please circle all that apply)

None	History of Percutaneous transluminal coronary angioplasty	Portosystemic Shunt Operation
Abdominoperineal Resection	History of tissue graft heart valve replacement	Prostatectomy
Biopsy of breast	History of cystectomy	Replacement of bilateral hip joints
Biopsy of prostate	History of prostatectomy	Replacement of bilateral knee joints
Coronary artery bypass	Hysterectomy	Splenectomy
Entire transplant (kidney)		
Excision of basal cell carcinoma	Kidney biopsy	Surgical biopsy of skin
Excision of melanoma	Low anterior resection of rectum	Total Nephrectomy
Excision of squamous cell carcinoma	Lumpectomy of left breast	Total Orchidectomy
History of Colostomy	Lumpectomy of right breast	Total Replacement of left Hip
History of tubal ligation	Mastectomy of Left Breast	Total Replacement of left Knee
History of appendectomy	Mastectomy of Right Breast	Total Replacement of right hip
History of bilateral mastectomy	Mechanical Heart Valve Replacement	Total Replacement of right Knee
History of cholecystectomy	Oophorectomy	Transplantation of heart
History of colectomy	Pancreatectomy	Transplantation of liver
History of liver excision	Extraction of kidney stone w/ frag procedure	
Other: _____		

**Skin Disease History:** (please circle all that apply)

None	Contact dermatitis from poison ivy	Malignant Melanoma
Acne	Dysplastic nevus of skin	Pruritus of scalp
Actinic Keratosis	Eczema	Psoriasis
Asteatosis Cutis	History of asthma	Squamous Cell Carcinoma
Basal cell carcinoma	History of hay fever	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	Grandchild

**Medications:** { } Yes    { } None    (If Yes, please list current medications)

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**Allergies to Medications:** { } Yes    { } No    (If Yes, please list)                    **Latex Allergy** { } Yes    { } No

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**Social History:** (please circle all that apply)

Current Smoker	Former Smoker	Vape	Nicotine gum/patch
Never Smoked	Drug Use	Smokeless Tobacco	Other

Do you have a **Healthcare Proxy?** (This is a person who can make your healthcare decisions for you if you are unable to communicate them yourself.) { } Yes    { } No

Full Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_