GRAND ISLAND Dermatology
INNOVATIVE SKIN CARE

Full Name: _____
Date of Birth: _____
Address: _____
_____
_____

Social Security Number: _____ - _____- _____
Gender: M F
Primary Phone: _____
Mobile Phone: _____
Work Phone: _____

Email Address ***(required)***: _____

Relationship Status: S M D W Other

Your Employment: _____

Providers:
Primary Care Physician: _____
Referring Physician: _____
Pharmacy Name and City: _____

Social History:
Smoking: Are you a: Non-Smoker Current Smoker Former Smoker

Skin Health: Do you wear sunscreen? Y N Do you tan at a tanning bed? Y N

Family History:
Do you have a family history of Melanoma? Y N If yes, which relative? _____

We will review your medications, allergies, and medical/surgical history in the exam room

Patients 64+ Only

Do you have a health care proxy? (a legal document appointing someone to make healthcare decisions on your behalf)

- □ Yes ➢ Please provide details below
  - o Name: _____
  - o Phone #: _____
- □ No

Do you have a living will? (a legal document that spells out medical treatments you would and would not want to be used to keep you alive)

- □ Yes ➢ **Please circle**:
  - ◦ Full Code
  - ◦ Do not intubate
  - ◦ Do not resuscitate
- □ No

Grand Island Dermatology, PC
Conditions of Office Visits

Print Patient Name: _____ SSN: _____-____-_____ Date of Birth: ____/____/_____

1. CONSENT FOR TREATMENT
I understand that I may have a condition requiring diagnostic procedures, physical examination and/or medical treatment. I hereby voluntarily consent to such diagnostic procedures including, but not limited to, laboratory testing, physical examination and such medical treatment as deemed necessary by my health care providers. Photos may also be taken of you and your condition and placed in your medical record for patient care purposes. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided at GRAND ISLAND DERMATOLOGY.

2. AUTHORIZATION FOR RELEASE OF INFORMATION
I hereby authorize GRAND ISLAND DERMATOLOGY to furnish from my medical records any requested information or excerpts to any insurance company or third-party payer for the purpose of obtaining payment of the account, or any entity providing care to the patient (medical specialist, hospital, radiology, oncology, pathology, imaging center, skilled nursing facility, health care facility etc.)

3. FINANCIAL AGREEMENT
I agree, whether I sign as the patient or the legal representative of the patient that in consideration of the services rendered to the patient, that I individually obligate the patient and myself to pay the account. Arrangements that are different from this must be made with the office. If charges are denied for any reason by my insurance company I am liable for all charges for my visits at GRAND ISLAND DERMATOLOGY.

4. CONSENT FOR TELEMEDICINE SERVICES
Telemedicine involves the use of electronic communications to enable health care providers to evaluate and manage a patient without the patient being present in the office. Although this does not improve access to medical care, there are potential risks. Risks include information transmitted may not be sufficient, delay in medical treatment, judgement errors, lack of access to complete medical record and rarely, breach of privacy of personal medical information. I give consent to telemedicine services.

For more complete description of the potential uses and disclosure of your health information for treatment, payment and healthcare, refer to GRAND ISLAND DERMATOLOGY'S Notice of Privacy Practices.

I understand that I have the right to review the Notice of Privacy Practices prior to signing the consent. The terms of the Notice of Privacy Practices may change and you may write to our address for a revised copy.

You have the right to request that the provider restrict how your health information is used or disclosed to carry out treatment, payment, or healthcare operations; however GRAND ISLAND DERMATOLOGY is not required to agree to requested restrictions.

You have the right to revoke this consent in writing, except to the extent that the provider has taken action in reliance on it.

5. FINANCIALLY RESPONSIBLE PARTY ☐ Same as patient (if different, please complete section below)

Name _____ Relationship to patient: ☐ Parent ☐ Guardian ☐ Other (specify)_____

Address _____ Phone Number (____) _____-_____

Date of Birth ____/____/_____ Social Security Number _____-____-_____ Place of Employment_____

6. EMERGENCY CONTACT

Please list an emergency contact person: _____

Relationship: _____ Phone Number (____) _____-_____

Can we release Protected Health Information to this person: ☐ Yes ☐ No

7. OTHER INFORMATION:

May we contact you or leave a message on your home phone or cell phone regarding your health care issues? ☐ Yes ☐ No

Patient's Place of Employment_____

Please list an email to access your online portal: _____

UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON THE BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS

8. Signed: _____ Date: _____ Witness: _____

Relationship to Patient: _____ **Phone Number** (____) _____-_____