Illinois Dermatology Institute

PATIENT INFORMATION **(Please Print)** **Today's Date** ____/____/_____

Name:_____
Last First M.I.

Mailing Address:_____
Street City State Zip Code

Home Phone ( ) _____ Alternate Phone ( )_____
OK to leave message: ☐ Yes ☐ No OK to leave message: ☐ Yes ☐ No

Date of Birth: _____/_____/_____ S.S.# _____/_____/_____ Marital Status: _____ Spouse Name: _____

Age: _____ Sex: _____ Employment: ☐FT ☐PT ☐FT-Student ☐PT-Student ☐Retired ☐Unemployed

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name:_____
Last First M.I.

Mailing Address:_____
Street City State Zip Code

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

Date of Birth: _____/_____/_____ S.S.# _____/_____/_____ Age: _____ Sex:_____ Relation: _____

INSURANCE INFORMATION (After you have finished completing this form, please bring it to the front desk along with your current insurance card and photo ID)

Primary Insurance Co. Name _____
Name of Insured _____
Address of Insured (if different) _____
_____
Date of Birth of Insured _____
Employer Name _____
Relationship of patient to Insured _____

Secondary Insurance Co. Name _____
Name of Insured _____
Address of Insured (if different) _____
_____
Date of Birth of Insured _____
Employer Name _____
Relationship of patient to Insured _____

In case of Emergency, who should be notified? _____**Phone** ( )_____

Can we discuss your medical conditions with other members of your household? ☐ Yes ☐ No Specify _____

Referred by: ☐ Physician _____ ☐ Family/Friend _____

How did you hear about us? ☐ Friend/Family ☐ Internet ☐ Advertisement ☐ Insurance Referral ☐ Yellow Pages ☐ Physician ☐ Other_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments will be collected. **We accept payment in the form of cash or credit card.** If we do accept a check for payment, and the check does not clear the bank, a $25.00 service fee will be automatically added to your account. **Please note that any procedure performed in the office may be billed separately and in addition to the office visit fee.** Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature_____Date_____/_____/_____

If patient is a minor, Print name of responsible party_____Relationship_____

Please check all of the following boxes that apply:

Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ BPH (enlarged prostate)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Gastric Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other:_____
- ☐ ***No Past Medical Problems***

Past Surgeries

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Breast Reduction
- ☐ Breast: Breast Implants
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Dz
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: PTCA (angioplasty)

Past Surgeries Continued

- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Heart Transplant
- ☐ Joint Replacement: Knee (Right)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Nephrectomy (Kidney Removal)
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): TURP
- ☐ Skin: Skin Biopsy
- ☐ Skin: Basal Cell Carcinoma Surgery
- ☐ Skin: Squamous Cell Carcinoma Surgery
- ☐ Skin: Melanoma Surgery
- ☐ Spleen (Splenectomy): Spleen Removal
- ☐ Testicles (Orchidectomy): Testicle Removal
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Other:_____
- ☐ ***No Past Surgical Procedures***

Skin Disease History

- ☐ Acne
- ☐ Actinic Keratoses (precancers)
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ ***No Past Skin Problems***

Skin History

Do you wear sunscreen?

- ☐ Yes. What SPF do you apply?_____
- ☐ No

Do you tan in a tanning salon?

- ☐ Yes
- ☐ No

Family History

Is there a family history of melanoma?

Mother	☐ Yes ☐ No
Father	☐ Yes ☐ No
Sibling	☐ Yes ☐ No
Grandmother	☐ Yes ☐ No
Grandfather	☐ Yes ☐ No

Medications

With your permission, we can obtain prescription information directly from your pharmacy?

☐ **Yes** ☐ **No (if no, please list all below)**

If yes, please list **non-prescription** medications below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

☐ ***No Current Medications***

Allergies: (Please list all allergies)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

☐ **No Drug Allergies**

Sexual History

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with two or more partners
- ☐ Same gender partner

Drinking Alcohol History

- ☐ No alcohol
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Smoking History

- ☐ Currently smokes daily
- ☐ Currently smokes but not daily
- ☐ Former smoker
- ☐ Has never smoked

Family History of Disease

- ☐ Yes
- ☐ No

Relative and Disease

_____

Relative and Disease

_____

Review of Systems *Have you recently experienced any of the following:*

- ☐ Changing , bleeding or itching mole/lesion
- ☐ Rash
- ☐ Itching
- ☐ Burning Skin
- ☐ Fever/Chills
- ☐ Unintentional Weight Loss
- ☐ Night Sweats
- ☐ Muscle Weakness
- ☐ Joint Aches
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Blurry Vision
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Abdominal Pain/Nausea/Vomiting
- ☐ Bloody Stool
- ☐ Depression
- ☐ Hay Fever
- ☐ Problems Healing
- ☐ Burning with urination
- ☐ Heat or cold intolerance
- ☐ Frequent nose bleeds
- ☐ ***Does not apply***

Alerts

- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Artificial Joint Placed in Last 2 Years
- ☐ Artificial Heart Valve
- ☐ Antibiotic Prophylaxis
- ☐ History of Scarring (Keloid)
- ☐ History of Passing Out (Vasovagal)
- ☐ Organ Transplant Recipient
- ☐ Immunosuppressed (Low Immunity)
- ☐ Allergy to Adhesive
- ☐ Pregnant or Planning a Pregnancy
- ☐ Breast Feeding
- ☐ Stomach Upset with Antibiotics
- ☐ Yeast Infection with Antibiotics
- ☐ Allergy to Topical Antibiotics
- ☐ Anti-coagulated (on blood thinners)
- ☐ Allergic to Lidocaine
- ☐ Rapid Heart Beat with Epinephrine
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ History of MRSA
- ☐ ***Does not apply***

Vaccines

Have you ever had the pneumonia vaccine?

- ☐ Yes
- ☐ No

Female Patients Only

Are you pregnant?

- ☐ Yes Due Date_____
- ☐ No

Are you breast feeding?

- ☐ Yes
- ☐ No

Are you trying to get pregnant?

- ☐ Yes
- ☐ No

Primary Care Physician

_____

Phone_____

Address_____

Send Test Results to PCP

☐ Yes ☐ No

Prescription Coverage

- ☐ Yes
- ☐ No

Preferred Pharmacy _____

Phone_____

Zip code_____

Preferred Language

- ☐ English
- ☐ Other:_____

Race

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other Race:_____

Ethnic Group

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Advance Care Plan

For Patients 65 and Older

The information requested below is for Medicare's Quality Initiative Program

Answer the question below:

Do you have an Advance Care Plan or Surrogate Decision Maker (Ex: living Will, Health Care Proxy)?

- ☐ Yes
- ☐ No
- ☐ Declined to Answer

The notice of privacy practice for the office of Illinois Dermatology Institute, LLC is available at the front desk and on our website at www.idi-hinsdale.com. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

Section 1 of this document provides your acknowledgement that you have read our Notice of Privacy Practices.

Section 2 requests your response to notification format and designation of a family member or other designee that we may contact and discuss your medical care in the event of an emergency or for the purpose of the individual items as checked below.

Section 3 provides the opportunity to opt in or opt out of receiving marketing communication from our office.

Section 1 - Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office Illinois Dermatology Institute, LLC

_____ _____

Patient Name *Date*

_____ _____

Date of Birth *MRN **(office use)***

Section 2 – Notification and Emergency Designee

I give permission to Illinois Dermatology Institute, LLC (IDI) and staff to perform the following duties in an effort to maintain continuity of care.

Confirm/revise my appointment times by calling my home, business, and any other designated phone number.

☐ **YES** ☐ **NO**

Leave a message of normal test result on my home answering machine or with a specified family member.

☐ **YES** ☐ **NO**

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

_____

Designated Person *Contact Number*

Section 3 – Marketing communication

IDI would like to share **new product, discounts or service information directly to you**, our patient. The information may be communicated by phone call, texting, letter, or email. **(You are able to change your decision at any time by notifying our office.)**

☐ **I wish to opt IN** Email Address _____

☐ **I wish to opt OUT I do not** wish to receive marketing information.

I understand the information provided to me in the privacy notice and I have indicated my response to questions in each section

_____ _____

Patient Signature and Phone number *Date*

ILLINOIS DERMATOLOGY INSTITUTE
Excellence and Compassion

Patient Responsibility Policy

1. It is the patient's responsibility to check to see if we are in-network.

2. If you have a HMO insurance, you are responsible for your referrals. Referrals are only valid for 90 days from the issue date and are only good for as many visits as your primary doctor has approved.

3. You are responsible for knowing the policies of your insurance, such as: co-pay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc.

4. Co-pays and Self-pay procedures are due at the time of service, no exceptions.

5. Preventative care coverage does not cover skin cancer screenings. Skin exams will be billed and coded as an office visit based on the American Medical Association's guidelines and the conditions diagnosed and treated during that visit. Your insurance will indicate your financial responsibility based on the individual coverage within your plan.

6. If you need to cancel and/or reschedule an appointment, please notify the office 48 hours in advance.

7. If you cancel in less than 48 hours, or no show your appointment, you will be charged a $30.00 fee.

8. For the consideration of our patients who want to be seen, if you repeatedly cancel less than 48 hours in advance or no show your appointment, we have the right to discharge you as a patient.

9. Please call the office if you are going to be late to your appointment. It will be up to the discretion of the physician if you will be seen if you arrive more than 30 minutes late.

I have read and understand the patient responsibility policy of Illinois Dermatology Institute, LLC.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____