Pariser
DERMATOLOGY SPECIALISTS
Established 1946

TODAY'S DATE _____

CHART NO. _____ ACCOUNT NO. _____

PATIENT INFORMATION - PLEASE PRINT

NAME LAST	FIRST	MIDDLE	SEX	DOB	SOCIAL SECURITY NUMBER

HOME ADDRESS	APT	CITY	STATE	ZIP

MAILING ADDRESS	PO BOX	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	EMAIL ADDRESS

EMPLOYER NAME	EMPLOYER ADDRESS

EMERGENCY CONTACT: PLEASE LIST A CONTACT LOCATED OUTSIDE OF YOUR PRIMARY RESIDENCE

NAME _____ PHONE NUMBER _____

MARITAL STATUS ☐ CHILD ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

PATIENT RACE PATIENT ETHNICITY PREFERRED LANGUAGE

PREFERRED METHOD OF CONTACT

REFERRING DOCTOR: _____ PRIMARY CARE DOCTOR _____

HOW DID YOU HEAR ABOUT US? FRIEND ☐ INTERNET ☐ NEWSPAPER ☐ INSURANCE COMPANY ☐ TV ☐ RADIO ☐ OTHER ☐

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
CERTIFICATE NUMBER	CERTIFICATE NUMBER
GROUP NUMBER	GROUP NUMBER
SUBSCRIBER NAME	SUBSCRIBER NAME
SUBSCRIBER SS#	SUBSCRIBER SS#
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER DATE OF BIRTH

GUARANTOR INFORMATION

NAME LAST	FIRST	MIDDLE	SEX	DOB	SOCIAL SECURITY NUMBER

HOME ADDRESS	APT	CITY	STATE	ZIP

MAILING ADDRESS	PO BOX	CITY	STATE	ZIP

HOME PHONE	CELL	WORK	EMAIL ADDRESS

EMPLOYER NAME	EMPLOYER ADDRESS

OFFICE POLICIES

·You are responsible for the entire balance on your account at the time service is rendered unless we have a special contractual relationship with your insurance company. Please discuss this with us in advance to avoid misunderstandings.

·We expect full payment for copayments and deductibles at the time services are rendered.

·We cannot bill insurance for cosmetic or non-covered services. Full payment must be made at the time of service.

·In the event that your balance is unpaid, you agree to pay a collection fee of 33 1/3% and all attorney fees (including litigation, if necessary) related to the collection of the unpaid balance.

·If you need to cancel an appointment, we request 24 hour advanced notification. Failure to cancel may result in a charge.

Signature states an understanding of the above information and authorization for the physician to examine and treat this patient as well as authorizes PDS to release medical information to your insurance company. Further, this is deemed consent to testing and/or results related to HIV or Hepatitis viruses.

Signature _____ Date _____

(Patient/Parent or Guardian if under 18)

MEDICARE AND TRICARE PATIENTS

Please read and sign so we may file for you

I request that payment of authorized Medicare/Tricare benefits be made whether to me or on my behalf to Pariser Dermatology Specialists,. LTD. For any services furnished by that group of physicians. I authorize any holder of any medical information about me to release to the Health Care Financing Administration/Tricare and its agents any information needed to determine these benefits for related services.

Signature _____ Date _____

Is Medicare your primary payer? Yes _____ No _____

NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Pariser Dermatology Specialists, Ltd's Notice of Privacy Practices.

Signature _____ Date _____

PATIENT INFORMATION

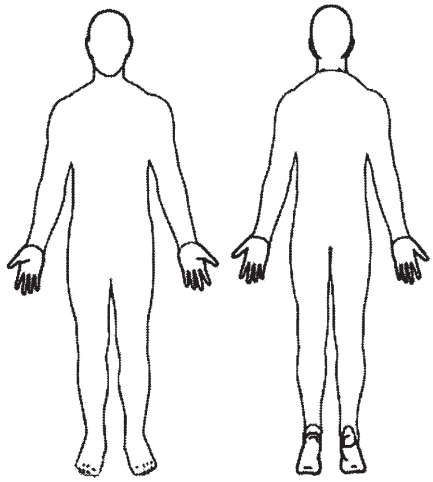
PATIENT NAME _____ D.O.B. _____ CHART NO. / ACCOUNT NO. _____

1. What is (are) your skin problem(s)? (rash, growths, warts, etc.) _____

2. How does it bother you? (itching, pain, appearance, burning, etc.) _____

3. How long have you had it? _____

4. Please draw on the chart where your skin problem is by marking x's on the adjacent figure.



PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

5. Have you had any other skin problems? ❑ YES ❑ NO If yes, please list.

6. Does anyone in your family have skin problems? If yes, please list. ❑ YES ❑ NO

7. Has a doctor given you any external or internal treatment for the skin? If yes, please list. ❑ YES ❑ NO

8. Have you used any non prescription treatments on your skin? If yes, please list. ❑ YES ❑ NO

9. Are you allergic to any medicines? (penicillin, aspirin, etc.) If yes, please list. ❑ YES ❑ NO

10. Does anything touching your skin cause a rash? (jewelry, medicated creams, perfume, etc.) If yes, please list. ❑ YES ❑ NO

11. Are you being treated by any other physicians? If yes, for what? ❑ YES ❑ NO

12. Are you taking any pills, tablets or medications for any medical condition? If yes, please list. ❑ YES ❑ NO

13. Have you had any surgical operations? If yes, please list. ❑ YES ❑ NO

14. Please check any of the following areas related to, or any specific medical problems, you now have or have had in the past.

- ❑ Allergies
- ❑ Hives
- ❑ Eczema
- ❑ Stomach Ulcer/Bowel
- ❑ Blood/Bleeding Disorder
- ❑ High Blood Pressure
- ❑ Thyroid
- ❑ Diabetes
- ❑ Heart
- ❑ Urinary System/Kidney
- ❑ Reproductive Organs
- ❑ Infectious Diseases
- ❑ Eyes
- ❑ Ears/Nose/Throat/Mouth
- ❑ Headaches/Seizures
- ❑ Psychological Disorder
- ❑ Bones / Joints / Arthritis
- ❑ Respiratory
- ❑ Other (please list) _____

15. Do you need to take any antibiotics before you have any surgical or dental work done? ❑ YES ❑ NO

16. For women: Are you pregnant or trying to get pregnant? ❑ YES ❑ NO Are you using hormone or birth control pills, shots or patches? ❑ YES ❑ NO

17. Do you drink alcohol? ❑ YES ❑ NO

18. Do you smoke? ❑ YES ❑ NO

19. Have you ever used a tanning bed? ❑ YES ❑ NO If yes, how many times? _____

PLEASE INDICATE THE TYPE OF EXAMINATION YOU WANT BY CHECKING BELOW

❑ Please limit my examination to the above mentioned problem only.

❑ Please examine the above mentioned problems as well as the following concerns _____

❑ Would you like to be scheduled for a "total" skin exam at a later date?