OZARK DERMATOLOGY

Fayetteville: 479.443.5100 Fax: 479.443.5117
Bentonville: 479.273.7006 Fax: 479.273.9497
Siloam Springs: 479.373.6566 Fax: 479.373.6567
Lowell: 479.347.2700 Fax: 479.347.2701

Demographics

Name: Last ____________________________ First ____________________________ MI _____ Date of Birth: _______________ SSN: ___________________________________

Gender: M F (*For medication management purposes we require you to identify your gender assigned at birth.)

Address: ____
Street or PO Box City State Zip

Phone: Cell (____) ___________________ Work (____) __________________

Home (____) __________________ Okay to leave detailed message? Cell _____ Home_____

Communication preference: Cell or Home Preferred language: ____________________

Marital Status: Single Married Widowed

Race: White African American/Black Asian Hispanic Other: ________________________

Would you like access to our patient portal? YES NO (if yes, please provide email address)

Email address: ____

Primary Care Physician: ________________________ Referring Physician ___________________________

Emergency Contact: __________________________________ Relationship: _______________________

Phone # (____) _______________

Responsible Party (if other than patient)

Name: Last _______________________________ First ______________________________ MI _________

Date of Birth: ____________ SSN: ________________ Relationship to patient: _________________________

Address: ____
Street or PO Box City State Zip

Phone: Cell (____) __________________ Work (____) ________________ Home (____) _________________
(only list if other than cell)

Insurance

Primary Insurance

Insurance Company: ____

Policy Holder: ____ Date of Birth: _______________

SSN: ____________________________________ Relationship to patient: _____________________________

Employer: ____ Work Phone #: (____) ___________________

Secondary Insurance

Insurance Company: ____

Policy Holder: ____ Date of Birth: _______________

SSN: ____________________________________ Relationship to patient: _____________________________

Employer: ____ Work Phone #: (____) ___________________

Medical Information Release

I authorize Ozark Dermatology Clinic (ODC) to discuss my protected health information (PHI) with the individuals listed below. I understand that ODC cannot discuss any information with any persons **not** listed below. This authorization is valid until revoked in writing.

* **People we can share your information with (HIPAA):**____

* **Patient Signature:** ____Date: _________________

* = required

Complete the back page →

***Patient Name**: ______________________________________ DOB:_________________ Date: _____________

Policies and Consents

HIPAA Acknowledgement: ODC may use and disclose your protected health information to carry out treatment, payment and health care operations. We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.

Please sign as an acknowledgement of receipt. acknowledge that I have received a copy of this office's Notice of Privacy Practices.

***Signature**:____ Date: _________________

Medical Photography Consent: Medical photographs may be taken and stored in patients' electronic medical chart.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of our Notice of Privacy, but it could not be obtained because:

Patient refused　　Emergency situation

Unable to communicate with patient　　Other: ____________________________

Employee Signature: ____Date: _________________

Cancellation Policy: Treatment outcomes are dependent on a mutual relationship between provider and patient. Keeping your appointments at the suggested intervals is imperative to good treatment outcomes. With this, we request a 24-hour notice for any cancellation**. If a 24-hour notice is not received there could be a $35.00 fee assessed per 15-minute appointment slot.** I understand that if I am late to my appointment ODC reserves the right to reschedule my appointment. **I also understand that failure to keep surgical appointments or repeated no shows/last minute cancellations/late arrivals will result in termination of care from ODC.**

Treating Minors: Ozark Dermatology Clinic will not treat a minor as new patient without the presence of a parent or guardian. In some circumstances a written consent can be put on file to treat a minor for follow up appointments. The treating provider reserves the right to refuse treatment without a parent or guardian even with written consent.

Payment Policy:

- I understand that I am responsible for verifying if Ozark Dermatology is an in-network provider under my insurance. I am responsible for knowing my benefits. Benefit verification/quotes are only provided by Ozark Dermatology Clinic for large surgical procedures. Quotes are not a guarantee of benefits but only an estimate and are subject to the terms and conditions of my insurance. I understand that Ozark Dermatology Clinic reserves the right to collect pre-payments for procedures.
- All copays, coinsurance and deductibles are due at the time of my service. I understand that Ozark Dermatology Clinic tries to provide accurate claim information at check out but all claims are subject to review by clinic billers and additional charges maybe assessed at the time of claim submission.
- Some services are considered non-covered, cosmetic or not medically necessary. Though ODC attempts to inform patients prior to services rendered, I understand that I am responsible for payment of these charges.
- Ozark Dermatology Clinic will file all claims on my behalf. They will make every attempt to collect payments from my insurance. I accept that all payments from my insurance will be assigned to Ozark Dermatology Clinic. I will also provide all required information to my insurance to expedite timely claims reimbursement.
- I understand that as a parent of a minor that the financial responsibility falls under the parent seeking treatment. Ozark Dermatology Clinic is not responsible for determining financial responsibility in the case of divorced parents.
- All pathology charges are separate from office visit charges and are not collected at the time of service. Some specimens require specialized testing and charges are determined once the pathologist reviews the case. I understand in some instances Ozark Dermatology Clinic may refer my labs to an outside organization.
- Non-payment of services may result in my account being referred to collections. I understand that all appointments will be cancelled if my account is referred to collections and that Ozark Dermatology Clinic reserves the right to terminate me as a patient for non-payment.

* Signature: ____ Date:_____________

Medical History

* **Patient Name**: ____ DOB:_________________ Date: _____________

Primary Care Physician: ____

Referring Physician: ____

Pharmacy: _________________________________ Location: ____

Height_____________ Weight_______________(both height and weight are required for prescriptions)

Skin Related Illnesses:

Basal Cell Carcinoma When: ___/___ Location: ________________ Treating clinic: __________________________

Squamous Cell Carcinoma When: ___/___ Location: _________________ Treating clinic: _________________________

Malignant Melanoma When: ___/___ Location: _________________ Treating clinic: __________________________

Do you have a history of? Pre-cancers / Abnormal Moles / Skin Infection / Recurrent Rashes
Psoriasis / Eczema / Other______________________________

Past Medical History:

Have you had any problems in the past with the following medical systems?

	Yes	**No**		**Yes**	**No**
Eyes	☐	☐	Stomach/Bowel	☐	☐
Ears/Nose/Throat	☐	☐	Kidneys	☐	☐
Heart	☐	☐	Joints/Muscles	☐	☐
Artificial Valves/Joints	☐	☐	Neurological	☐	☐
Pacemaker	☐	☐	Diabetic/Thyroid	☐	☐
Lungs	☐	☐	Bleeding Disorder	☐	☐
			Prone to fainting?	☐	☐

Other: ____

Females: Are you pregnant? ☐ Planning pregnancy? ☐ Are you breastfeeding? ☐

Drug allergies and reaction: ____

Other allergies or sensitivities: ____
(Examples: latex, adhesive, lidocaine, epinephrine, dust mite, etc.)

CURRENT MEDICATIONS: Please list below or provide a list for staff to copy.

RX Name: ____ Dosage ________ How often? ___________________

RX Name: ____ Dosage ________ How often? ___________________

RX Name: ____ Dosage ________ How often? ___________________

RX Name: ____ Dosage ________ How often? ___________________

RX Name: ____ Dosage ________ How often? ___________________

RX Name: ____ Dosage ________ How often? ___________________

RX Name: ____ Dosage ________ How often? ___________________

RX Name: ____ Dosage ________ How often? ___________________

RX Name: ____ Dosage ________ How often? ___________________

Complete the back page →

* **Patient Name**: ______________________________________ DOB:________________ Date: _____________

Over-the-Counter Medications and Vitamins:

____

____

Have you had a flu vaccine during the current flu season (Oct-March)? Yes No Month _________ Year _________

If you are 65+, have you received the pneumonia vaccine? Yes No Month _________ Year _________

FAMILY MEDICAL HISTORY:

	Mother	Father	Blood Relative
Diabetes	☐	☐	☐
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Kidney Disease	☐	☐	☐

	Mother	Father	Blood Relative
Asthma	☐	☐	☐
Hay Fever	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Skin Cancer	☐	☐	☐
Melanoma	☐	☐	☐
Bleeding Disorder	☐	☐	☐

Social History

Have you ever smoked? Yes No

Do you currently smoke? Yes No

If yes, do you smoke daily? Yes No

Do you smoke more than 1 pack a day? Yes No

Do You Drink Alcohol? Yes / No Frequency? ___________

Do You Use A Tanning Bed? Never / Currently / In the past

Do you have a history of blistering sunburns? Yes No

Employment Status:

Do you currently work? ☐ Full Time ☐ Part Time ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed

Occupation: ____

* Reason for today's visit? ____