Patient Name: _____ DOB: _____

Statement of Patient Financial Responsibility

Commonwealth Dermatology appreciates that you chose us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part, obligating you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill, including any deductible and co-payment/co-insurance as determined by your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Commonwealth Dermatology, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Commonwealth Dermatology, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Acknowledgement of Receipt of Privacy Practices & Patient Consent for Use and Disclosure of Protected Health Information

I acknowledge that Commonwealth Dermatology has posted a "Notice of Privacy Practices" for me to review in office, and a copy is available online at http://www.commonwealthderm.com. In addition, I may request a printed copy at any time from the office staff.

With my consent, Commonwealth Dermatology, may use and disclose protected health information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). Please refer to Commonwealth Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures. Commonwealth Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to Commonwealth Dermatology, 3055 Washington Road Suite 203, McMurray, PA 15317.

Consent for Treatment and Authorization to Release and Receive Information

I hereby authorize Commonwealth Dermatology, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures. I further authorize Commonwealth Dermatology, to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment. I authorize Commonwealth Dermatology to send and receive information with my pharmacy, including my prescription fill history. This information is used to ensure we have an up to date medication history and to prevent medication interactions.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. If you no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, you may be discharged from care. The Practice will notify you in writing, via certified mail, if you are discharged from care.

Patient Portal

You can now access your medical information using our patient portal: update your chart, receive test results, and send us messages. By providing us with your email address, you are giving us consent to activate your online portal.

Acceptance of the Above Policies

By signing below, I am consenting to the statement of financial responsibility, consent for treatment and authorization to release information, cancellation / no show policy, and indicating my preference on patient portal use.

Patient/Guarantor Signature _____ Date _____

Commonwealth DERMATOLOGY

DATE:_____

NEW PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI)	Social Security Number		
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	WHICH IS PREFERRED (H,W,C)?
EMAIL SO WE MAY GIVE YOU ONLINE ACCESS TO YOUR MEDICAL INFORMATION:	SEX	DATE OF BIRTH	
MARITAL STATUS	**OCCUPATION**		
EMPLOYER	WORK ADDRESS		
IS CONDITION WORK RELATED?			
SPOUSE'S NAME (LAST,FIRST, MI)	SPOUSE'S DATE OF BIRTH		
PRIMARY CARE PHYSICIAN	ADDRESS	PHONE	
HOW DID YOU FIND OUT ABOUT US?			

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME		RELATIONSHIP
ADDRESS		HOME PHONE
OCCUPATION	EMPLOYER	WORK PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	NAME OF POLICY HOLDER	
GROUP #	CERTIFICATE / POLICY/ ID#	POLICY HOLDERS DATE OF BIRTH
MEDICARE#	MEDICAID #	POLICY HOLDERS SOCIAL SECURITY NUMBER
SECONDARY INSURANCE COMPANY	NAME OF POLICY HOLDER	POLICY HOLDERS SOCIAL SECURITY NUMBER
GROUP #	CERTIFICATE / POLICY/ ID#	POLICY HOLDERS DATE OF BIRTH

Commonwealth DERMATOLOGY

Patient Name: _____ DOB: _____

Today's Date: _____

History and Intake Form

Medication allergies: _____

Current medications: (Please write below or give us your written list)

Name_____Dose_____Frequency_____ **Name_____Dose_____Frequency_____**
Name_____Dose_____Frequency_____ **Name_____Dose_____Frequency_____**
Name_____Dose_____Frequency_____ **Name_____Dose_____Frequency_____**
Name_____Dose_____Frequency_____ **Name_____Dose_____Frequency_____**

Pharmacy name: _____ **Pharmacy phone number:** _____

Who is your primary doctor? _____ **How did you hear about us?** _____

What is the reason for today's visit: _____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung cancer
Atrial fibrillation	GERD (acid reflux)	Lymphoma
Bone Marrow transplant	Hearing Loss	Prostate cancer
Prostate enlargement	Hepatitis (liver disease)	Radiation treatment
Breast Cancer	High blood pressure	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	High cholesterol	
Coronary Artery Disease	Hyperthyroidism	NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix removed	Knee Replacement (L, R, Both	Prostate biopsy
Bladder removed	Kidney Biopsy	Prostate removal: cancer
Breast: biopsy	Kidney stone removal	Prostate removal: TURP
Breast: Lumpectomy (L, R, Both)	Kidney removal	Rectum: resection
Breast: Mastectomy (L, R, Both)	Liver partial removal	Skin: Basal cell carcinoma
Colon removal	Liver transplant	Skin: melanoma
Colostomy bag	Liver shunt	Skin: skin biopsy
Gallbladder removal	Ovary removal for endometriosis	Skin: squamous cell carcinoma
Heart valve replacement (pig)	Ovary removal for cancer	Spleen removal
Heart valve replacement (metal)	Ovary removal for cyst	Tescticle removal
Heart: catheterization	Tubal ligation	Hysterectomy
Hip Replacement (L, R, Both)	Pancreas partial removal	NONE

Other _____

Skin Disease History: (Please circle any that apply)

Acne	Eczema	Precancerous moles
Actinic keratosis (pre-cancers)	Flaking or itchy scalp	Psoriasis
Asthma	Hay fever / allergies	Squamous cell skin cancer
Basal cell skin cancer	Melanoma	Other: _____
Blistering sunburns	Poison Ivy	_____

Social History: (Please circle all that apply)

Smoking history:	**Alcohol Use:**	
Currently smoke	None	Do you wear sunscreen? Yes No
If yes, how many / day_____	Less than 1 drink per day	If Yes, what SPF_____
Has smoked in the past	1-2 drinks per day	Do use a tanning salon? Yes No
Never smoker	3 or more drinks per day	

How many times in the past year have you had 4 or more drinks in a day? _____

Did you get a flu vaccine this season? Yes / No Have you ever received the pneumonia vaccine: Yes / No

Occupation: _____ **Hobbies: _____**

Family History (Please circle all that apply)

Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Non Melanoma Skin Cancer	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Acne	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Arthritis	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Asthma	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Diabetes	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Eczema	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Hay Fever/Allergies	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Lupus	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Psoriasis	Mother	Father	Sister	Brother	Daughter	Son	Other_____

Review of Systems: Do any of these currently apply? (Please circle Yes / No)

Changing mole	Yes / No	Abdominal pain	Yes / No	Pacemaker	Yes / No
Rash	Yes / No	Bloody stool	Yes / No	Defibrillator	Yes / No
Problems with healing	Yes / No	Bloody urine	Yes / No	Artificial heart valve	Yes / No
Problems with scarring	Yes / No	Joint aches	Yes / No	Artificial joint	Yes / No
Fevers / chills	Yes / No	Muscle weakness	Yes / No	Joint replacement last 2 years	Yes / No
Night sweats	Yes / No	Neck stiffness	Yes / No	Premedication before surgery	Yes / No
Unintended weight loss	Yes / No	Headaches	Yes / No	Blood thinners	Yes / No
Problems with bleeding	Yes / No	Seizures	Yes / No	Hepatitis B or C	Yes / No
Immunosuppression	Yes / No	Cough	Yes / No	HIV / AIDS	Yes / No
Hay fever	Yes / No	Shortness of breath	Yes / No	Allergy to lidocaine	Yes / No
Chest pain	Yes / No	Wheezing	Yes / No	Heart racing with epinephrine	Yes / No
Thyroid problems	Yes / No	Anxiety	Yes / No	Adhesive allergy	Yes / No
Sore throat	Yes / No	Depression	Yes / No	Topical antibiotic allergy	Yes / No
Blurry vision	Yes / No	Latex allergy	Yes / No	MRSA	Yes / No
				Pregnant or planning to be	Yes / No