Arlington Dermatology

5301 Keystone Court
Certified by the American Board of Dermatology, Inc.
General & Cosmetic Dermatology, Mohs, and Laser Surgery

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Fax: 847-392-8439

Dear Valued Patient,

Thank you for requesting an appointment in our office.

Please print and complete the enclosed forms and bring them to your scheduled appointment.

When you arrive at our office, please present the following:

- Registration Forms
- Insurance card(s)
- Driver's license or ID
- Co-payment if required
- Medication list

Please be sure to check with your insurance to confirm you will be eligible for in-network coverage. If you have any questions regarding insurance coverage, please contact our office prior to your appointment and our billing staff would be happy to assist you.

If you have an insurance plan that requires a referral, you will need to contact your primary care physician and have them forward a referral to our office. We may not be able to provide services to you if a referral is not on file with our office by the scheduled appointment date and time.

If you had results sent over to our office from another facility, please call our office ahead of time to verify that we received everything prior to your appointment including a referral, if applicable.

Please arrive 20 minutes prior to your scheduled first appointment to allow us sufficient time to process your paperwork. For future follow-up appointments, please arrive 15 minutes prior to your appointment to allow time for the check-in process.

For more information about our practice, please visit us on the web at www.arlingtondermatology.net.

Thank you for choosing Arlington Dermatology.

Sincerely,

Arlington Dermatology providers and staff

Arlington Dermatology

5301 Keystone Court • Rolling Meadows IL • 60008
Phone • 847-392-5440 Fax • 847-392-8439

PATIENT INFORMATION

Date: _____

Patient Name: _____
(LAST) (FIRST) (M.I.)

(**If Applicable) Maiden Name:** _____

Date of Birth (mm/dd/yyyy): _____/_____/_____

Address: _____ **Apt/Unit#:** _____

City: _____ **State:** _____ **Zip Code:** _____

SSN #: _____ - _____ - _____ **Gender:** ☐ Male ☐ Female ☐Other

Home Phone #: ( ) _____ **Cell Phone #:** ( ) _____

Email: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Preferred Language: _____

Employer Name: _____ **Occupation:** _____

PATIENTS UNDER 18 YEARS OF AGE

Name of Responsible Party: _____
(LAST) (FIRST) (M.I.)

Responsible Party Date of Birth (mm/dd/yyyy): _____/_____/_____

Gender: ☐ Male ☐ Female ☐ Other **SSN #:** _____ - _____ - _____

Relationship to Patient: _____ **Responsible Party Phone:** ( ) _____

Responsible Party Address/Apt # (if different than above): _____

City: _____ **State:** _____ **Zip Code:** _____

INSURANCE INFORMATION

NO INSURANCE/SELF PAY AGREEMENT

INITIALS: _____

I agree to be personally and fully responsible for any and all charges accrued related to services provided by Arlington Dermatology. I also understand that I may not go back and choose to have a previous session switched from Self Pay to Insurance billed charges. *(Please skip to the signature line below if you have read the agreement above and initialed)*.

PRIMARY INSURANCE INFORMATION *(In order for us to file a claim on your behalf, this section must be completed by the patient.)*

Primary Insurance Name: _____

ID#: _____ **Group/Policy #:** _____

Policyholder Name: _____ **Policyholder's Date of Birth:** _____

Relationship to Patient: _____ **Subscriber's SSN #:** _____ - _____ - _____

HMO Primary Care Doctor (if applicable): _____

SECONDARY INSURANCE INFORMATION *(In order for us to file a claim on your behalf, this section must be completed, if applicable.)*

Primary Insurance Name: _____

ID#: _____ **Group/Policy #:** _____

Policyholder Name: _____ **Policyholder's Date of Birth:** _____

Relationship to Patient: _____ **Subscriber's SSN #:** _____ - _____ - _____

HMO Primary Care Doctor (if applicable): _____

AUTHORIZATION/ASSIGNMENT/ FINANCIAL RESPONSIBILITY

By signing below, I certify that I, or my dependent, have benefits issued by the above listed insurance plan(s) as completed by me, and hereby assign directly to ARLINGTON DERMATOLOGY any benefit for services rendered. I authorize the release of information when necessary to secure the payment of such benefits to ARLINGTON DERMATOLOGY. I authorize the use of the signature below on all insurance submissions as required. I fully understand that I am responsible for any and all charges associated with services rendered and agree to pay for costs not covered by my insurance, as per my individual contract with my insurance company. I understand that ARLINGTON DERMATOLOGY will attempt to recover any unpaid balance and may refer my account to a collection agency for any outstanding balance due.

My signature below indicates that I have read and understood the above statements and agreed upon them.
(Failure to sign this document may result in Arlington Dermatology rendering the patient ineligible for services.)

Patient Name: _____

Patient Signature (or Responsible Party): _____ **Date:** _____ /_____ /_____

PHYSICIAN & PHARMACY INFORMATION

PRIMARY CARE PHYSICIAN/REFERRING PHYSICIAN

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: ( ) _____ **Fax #:** ( ) _____

PHARMACY

Pharmacy Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: ( ) _____ **Fax #:** ( ) _____

CURRENT MEDICATION(S)

(If you already have a current medication list, please present it to the front desk and skip the table below)

Name of Medication (Ex: Spironolactone tablet)	**Dosage** (Ex: 25 mg)	**How often?** (Ex: Everyday/Twice a day)

Electronic Prescriptions:

Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. Your signature below provides us authorization to access this information on your behalf.

Patient Signature (or Responsible Party): _____ **Date:** _____ /_____ /_____

GENERAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

ALLERGIES

Name of Allergy	Type of Reaction

(If more room is needed, please write on the back of this sheet)

SOCIAL HISTORY

Tobacco Use: ☐ Never ☐ Current everyday; Date Started: _____ ☐ Former; Date Quit: _____

Alcohol Use: ☐ Never ☐ < 1 per day ☐ 1-2 per day ☐ 3 or more per day

SKIN DISEASE HISTORY

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative (s)? _____

Date of last Flu Vaccine: _____ ☐ Flu shot not administered
(Month / Year)

FEMALE PATIENTS

Are you currently pregnant? ☐ Yes ☐ No If yes, are you breastfeeding? ☐ Yes ☐ No

Are you using contraceptives? ☐ Yes ☐ No **Are you currently trying to conceive?** ☐ Yes ☐ No

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(Medicare requires the following questions to be asked of patients over the age of 65 regardless of if you are covered by a commercial insurance or are a Medicare beneficiary).

PATIENTS 65 YEARS OF AGE AND OLDER

Have you received a pneumonia vaccine? ☐ Yes ☐ No

Do you have a health proxy (POA) in the event you are unable to make your own decisions? ☐ Yes ☐ No

If yes, please list Designee name and phone number: _____

Do you have a living will? ☐ Yes ☐ No

Which of the following statements best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life. **(Copy of DNR required)**

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

PERSONAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

PAST MEDICAL HISTORY (please circle all that apply) ☐ NONE

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH (Benign Prostatic Hyperplasia)
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension/High Blood Pressure
HIV/AIDS
Hypercholesterolemia/High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other: _____

PAST SURGICAL HISTORY (please circle all that apply) ☐ NONE

Appendix Removed
Bladder Removed
Breast Biopsy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Biopsy
Kidney Stone Removal
Kidney Removed (Right, Left)
Kidney Transplant
Liver (Transplant, Hepatectomy, Shunt)
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovarian Cyst
Pancreatectomy
Prostate: Biopsy
Prostate Removed: Prostate Cancer
Prostate: TURP
Skin: Basal Cell Cancer Surgery
Skin: Melanoma Surgery
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer/Cervical Cancer
Other: _____

SKIN DISEASE HISTORY (please circle all that apply) ☐ NONE

Acne
Actinic Keratoses
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
Other: _____

REVIEW OF SYSTEMS

Please circle any of the following symptom(s) that pertain to your visit **today**:

INTEGUMENTARY (SKIN)

Changing Moles/Lesion(s)
Chapped Lips
Dry Skin
Hairloss
New Pigmented Skin Lesion(s)
Non-Healing/Bleeding Lesion(s)
Problems with Healing
Problems with Scarring (hypertrophic or keloid)
Rash

CONSTITUTIONAL / SYMPTOM(S)

Fever or Chills
Malaise
Night Sweats
Unintentional Weight Gain/Loss

GASTROINTESTINAL (G.I.)

Abdominal Pain
Constipation
Diarrhea

MUSCULOSKELETAL

Joint Aches
Muscle Weakness
Neck Stiffness

PSYCHIATRIC

Anxiety
Depression
Suicidal Ideation

HEMATOLOGIC/LYMPHATIC

Problems with Bleeding
Swollen Lymph Nodes

NEUROLOGICAL

Headaches
Seizures

ALLERGIC/IMMUNOLOGIC

Hay Fever
Immunosuppression

ENT AND MOUTH

Sore Throat

RESPIRATORY

Wheezing

EYES

Blurry Vision

GENITOURINARY (G.U.)

Bloody Urine

ENDOCRINE

Thyroid Problems

CARDIOVASCULAR

Chest Pain

OTHER

Allergy to Adhesive
Allergy to Latex
Allergy to Lidocaine
Allergy to Topical Antibiotic Ointments
Pacemaker
Premedication Prior to Procedures
Rapid Heart Beat with Epinephrine
Blood Thinner
Artificial Heart Valve
Artificial Joints Within Past Two Years
Defibrillator
HIV Positive
MRSA
Vasovagal Response
Hepatitis C Positive
FEMALE ONLY: Pregnancy or Planning a Pregnancy

OFFICE & FINANCIAL POLICIES

MEDICAL RECORDS POLICY

Arlington Dermatology reserves the right to charge for copies of medical records. Additional information regarding record fees can be found on the state of Illinios controller website at:

http://www.ioc.state.il.us/index.cfm/resources/general-resources/copy-fees

You may ask our medical records department and obtain an estimate of the actual costs related to your request. All requests for patient medical records by other medical providers directly will be done free of charge, with the exception of transfer of care purposes.

CO-PAYMENTS, DEDUCTIBLES, ACCOUNT BALANCES AND COLLECTIONS

Co-payments, coinsurances, deductibles, and account balances are due at the time of service. If your medical plan determines a service is "not covered" or "not medically necessary" you agree to be responsible for the charge as directed by your insurance plan. For any procedure, treatment, or visit that is not covered by your insurance plan but for which you have agreed to self-pay, full payment is required at the time of service.

We accept cash, checks, money orders, Visa, Discover, American Express, and MasterCard. Online bill pay is available on our website at www.arlingtondermatology.net. Your email address will be required in order to receive your electronic receipt of payment.

You agree that in order for us to collect any amounts you may owe, we or any third party whom we contract with in regards to your account may contact you. Methods of contact may include letters sent to your address or calls directed to any phone number associated with your account. **All accounts 90 days past due or more may be sent to collections.** You also agree that in the event of non-payment, you will bear the cost of any collections, court costs, witness fees and legal fees, should this be required.

CANCELLATION/NO SHOW POLICY

As a courtesy, we attempt to contact every patient to remind them of their appointment but cannot always guarantee this. If the patient cannot attend a scheduled appointment, it is the patient's responsibility or responsible party to call the office to cancel at least 24 hours prior to their scheduled appointment. Patients that miss a general appointment or cancel with less than a 24 hour notice will receive a notification postcard via mail as a one-time courtesy.

***PLEASE NOTE*:** Arlington Dermatology reserves the right to charge a fee for missed appointments or cancellations with less than 24 hour notice as follows:

- Surgical appointments (MOHS, excisions, etc.) = **$50**
- Cosmetic appointments (Lasers, Botox, Extractions, Chemical peels, etc.) = **$50**
- General appointments = **$25**

My signature below indicates that I have read and understood the above statements and agreed upon them.
(Failure to sign this document may result in Arlington Dermatology rendering the patient ineligible for services.)

Patient Name: _____

Patient Signature (or Responsible Party): _____ **Date:** _____ /_____ /_____

Relationship to patient: _____

RELEASE OF AUTHORIZATION INFORMATION

COMMUNICATION AUTHORIZATION

In the event that Arlington Dermatology needs to contact you regarding an appointment, lab results, medication, or any other reason, please select from the following:

(**Please note:** Arlington Dermatology will always attempt to reach you first before contacting authorized person(s))

Check all that apply:

- ☐ Speak only to me, no detailed messages authorized
- ☐ Speak to authorized person(s) as listed below if I'm unable to be reached after two attempts
- ☐ Detailed messages are authorized (Including pathology results)

RELEASE OF MEDICAL INFORMATION

I give authorization to Arlington Dermatology to discuss my medical and/or financial information with the person(s) listed below. This person(s) will also serve as my emergency contact(s) unless I specify otherwise.

Name	Relationship	Phone	Please Circle (You may circle both)	
			Financial	**Medical**
			Financial	**Medical**
			Financial	**Medical**

ACKNOWLEDGEMENT OF HIPAA/RECEIPT OF INFORMATION PRACTICES NOTICE

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that the above listed information may be used to:

- Conduct, plan, and direct my treatment and follow up care among multiple healthcare providers, as applicable
- Obtain payment from 3rd party payers
- Conduct normal healthcare operations such as quality assessment and physician certifications

I understand that I may request in writing to have the use or disclosure of my private information restricted in regards to treatment, payment, and healthcare operations. I also understand that Arlington Dermatology is not required to agree to my requested restrictions. In the case that Arlington Dermatology does agree to any restrictions requested, we are bound to abide by them as stated by you.

My signature below indicates that I have read and understood the above statements and agreed upon them.
(Failure to sign this document may result in Arlington Dermatology rendering the patient ineligible for services.)

Patient Name: _____

Patient Signature (or Responsible Party): _____ **Date:** _____ /_____ /_____

Relationship to patient: _____

(Office use only)

I attempted to obtain the patient's signature but was unable to do so as documented below.

Date:_____ Initials: _____ Reason: _____