Arlington Dermatology

5301 Keystone Court • Rolling Meadows IL • 60008
Phone • 847-392-5440 Fax • 847-385-0294

PATIENT INFORMATION

Date: _____

Patient Name:

_____
(LAST) (FIRST) (M.I.)

Name Pronunciation: _____ **(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

How did you hear about us: ☐Google ☐Facebook ☐Instagram ☐Yelp ☐Friend/Family ☐Other _____

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:** _____

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.)*

Secondary 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:** _____ /_____ /_____

Arlington Dermatology

HEALTH HISTORY

Patient Name _____ Today's Date _____

Date of Birth _____ Preferred Language _____

PHARMACY PREFERENCE

Local Pharmacy Name _____ City _____ Street _____

PATIENT'S MEDICAL HISTORY *(circle yes or no)*

ADD/ADHD	Yes	No	Blood Transfusion	Yes	No	Foot Problems	Yes	No	Murmur	Yes	No
Alcohol/Drug Abuse	Yes	No	Cancer	Yes	No	Glaucoma	Yes	No	Nerve/Muscle Disease	Yes	No
Allergies (other than meds)	Yes	No	Cataract	Yes	No	High Cholesterol	Yes	No	Osteoporosis	Yes	No
			Circulation Problems	Yes	No	Heart Attack	Yes	No	Pneumonia	Yes	No
Anemia	Yes	No	Colitis/Bowel Disease	Yes	No	Heartburn/GERD/Ulcers	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Congestive Heart Failure	Yes	No	High Blood Pressure	Yes	No	Sickle Cell	Yes	No
Arthritis	Yes	No	Chronic Obstructive Pulmonary Disease	Yes	No	HIV/AIDS	Yes	No	Stroke	Yes	No
Asthma	Yes	No				Jaundice	Yes	No	Thyroid Disease	Yes	No
Birth Defect/Genetic Problem	Yes	No	Depression	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
			Diabetes	Yes	No	Meningitis	Yes	No	Viral Hepatitis	Yes	No
Blood Clots	Yes	No	Emphysema	Yes	No	Mental Health Problems	Yes	No			

Other Medical History:

PATIENT'S SURGICAL HISTORY *(circle yes or no)*

Abdomen Surgery	Yes	No	Colon Surgery	Yes	No	Hernia Repair	Yes	No
Appendectomy	Yes	No	Cosmetic Surgery	Yes	No	Hysterectomy	Yes	No
Surgical Repair: Broken Bones/Fractures	Yes	No	C-Section	Yes	No	Joint Replacement	Yes	No
Coronary Artery Bypass Graft	Yes	No	Cholecystectomy (Gallbladder)	Yes	No	Ear Tubes	Yes	No
Brain Surgery	Yes	No	Adenoid/Tonsillectomy	Yes	No			
Breast Surgery	Yes	No	Sterilization	Yes	No			

Other Surgical History:

PATIENT'S SOCIAL HISTORY FOR 10 YEARS OLD AND UP

Tobacco Use	__Yes __NEVER __Quit __Passive	Comment _____
Packs/Day	__.25 __.5 __ 1 __ 1.5 __ 2 __ 3	Years of Smoking: __.5 __ 1 __ 2 __ 3 __ 4 __ 5 __ 10
Quit Date		__ Other _____

Alcohol Use	__ Yes __ No	
Drinks/Week		Glass(es) of Wine — Comment _____
		Can(s) of Beer
		Shot(s) of Liquor
		Drinks Containing 0.5 oz. of Alcohol

Internal Drug Use	__ Yes __ No	Comment _____
Per Week		Types: __ Marijuana Methamphetamines __ Cocaine __ IV

Sexually Active	__ Yes __ No __ Not Currently	Comment _____
Gender of Partners	__ Female __ Male	

Birth Control/Protection: __ Condom __ Pill __ Surgical __ Spermicide __ Rhythm __ Injection __ Abstinence

Patient Family History

Please complete the form below relating to your family's medical history.

Place an "X" in the appropriate box below (see example).

Relationship		Name	Status *(Circle)*	Cancer: Type and age of death (if applicable)	Diabetes – Type	Heart Failure	Hypertension (High Blood Pressure)	Asthma	High Cholesterol	Arthritis-Rheumatoid	Arthritis-Osteo	Stroke	Thyroid Disease	Seizures	Migraines	Rashes/Skin Problems	Other
Example	**Sister**	**Sally**	**Alive/Deceased**		**X**			**X**				**X**					
Parent	Mother		Alive/Deceased														
Parent	Father		Alive/Deceased														
Sibling			Alive/Deceased														
Sibling			Alive/Deceased														
Sibling			Alive/Deceased														
Sibling			Alive/Deceased														
Sibling			Alive/Deceased														
Patient's Children			Alive/Deceased														
Patient's Children			Alive/Deceased														
Patient's Children			Alive/Deceased														
Patient's Children			Alive/Deceased														
Grandparent	[1]MGM		Alive/Deceased														
Grandparent	[1]MGF		Alive/Deceased														
Grandparent	[2]PGM		Alive/Deceased														
Grandparent	[2]PGF		Alive/Deceased														

*1: Maternal 2: Paternal

FEMALE

HEALTH MAINTENANCE	DATE
Last Pap Smear	
Last Mammogram	
Last DEXA Scan	
Last Colonoscopy	
Last Tdap/Tetanus	
Last Pneumovax	
Last Flu Vaccine	
Last Shingles Vaccine	
Last COVID Vaccine	
Last Annual Exam	

MALE

HEALTH MAINTENANCE	DATE
Last PSA	
Last Colonoscopy	
Last Tdap/Tetanus	
Last Pneumovax	
Last Flu Shot	
Last Shingles vaccine	
Last COVID Vaccine	
Last Annual Exam	

Do you see other physicians? ___ Yes ___ No

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

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 regard 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: _____