PATIENT NAME:_____ ACCT #:_____

YEARLY INSURANCE UPDATES

"On behalf of our patients, Kansas City Dermatology files all claims to your insurance company. Failure to provide updated insurance information will result in statement being mailed to patient."

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name	Insurance Name:
Insurance Member #:	Insurance Member #:
Insurance Group #:	Insurance Group #:
Policy Holder's SS#:	Policy Holder's SS#:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's Address:	Policy Holder's Address:
Policy Holder's Sex : M___ F___	Policy Holder's Sex : M___ F___
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Employer's Name:	Policy Holder's Employer's Name:
Relationship to Patient:	Relationship to Patient:

I, hereby, authorize Kansas City Dermatology, P.A. to receive direct payment from insurance, release any information acquired in course of treatment/examination to my insurance for billing purposes. I am fully responsible for any amounts not paid by my insurance company.

Signed_____Date_____

KANSAS CITY DERMATOLOGY, P.A.

Patient's Request for Special Communication

Patient Name_____DOB:_____ Account #_____

I request that communication regarding my protected health information that is provided to me, other than verbally and in person, be provided to me by sending or calling the information to :

Address:_____Apt #____City:_____State:____Zip:_____

May we mail correspondence to this address? □ Yes □No

Home Phone # _____ A message can be left at this number □Yes □No

Work Phone # _____ A message can be left at this number □Yes □No

Cell Phone # _____ A message can be left at this number □Yes □No

Email Address _____

□ Yes, Kansas City Dermatology, P.A. may use this ***email*** address to inform me of health-related benefits or services that may be of interest to me.

□ My information may also be told to the following individuals:

Name _____Relationship_____

Address _____

Phone #_____

Name _____Relationship_____

Address _____

Phone#_____

This request will be kept in place at all times until I revoke this request at any time in writing and submitting such request to Kansas City Dermatology, P.A.

_____

Signature

_____

Signature of Personal Representative of Patient

_____

Description of Representative's Authority to Act for Patient

_____

Date

ON_____I RECEIVED KANSAS CITY DERMATOLOGY, P.A. NOTICE OF PRIVACY PRACTICES

_____ **DATE_____**

Patient Signature

KANSAS CITY DERMATOLOGY, P.A.
HEALTH HISTORY FORM

Today's Date_____

Last Name_____ First Name_____ Date of Birth_____

Do you or have you ever had these diseases or conditions (please, check Yes or No)

RESPIRATORY:

Bronchitis	YES □ NO □
Emphysema	YES □ NO □
Asthma	YES □ NO □
Chronic Cough	YES □ NO □
Shortness of Breath	YES □ NO □
Wheezing	YES □ NO □
Other_____	

CARDIOVASCULAR

High Blood Pressure	YES □ NO □
Chest Pain	YES □ NO □
Heart Attack	YES □ NO □
Arrhythmia	YES □ NO □
Phlebitis	YES □ NO □
Hardening of the Arteries	YES □ NO □
Artificial Valve	YES □ NO □
Pacemaker/Defibulator	YES □ NO □
Feel light headed/pass out	YES □ NO □
Feel faint with procedures	YES □ NO □
Other_____	YES □ NO □

IMPLANTS

Cochlear Implant	YES □ NO □
Bladder Stimulator	YES □ NO □
Brain Stimulator	YES □ NO □
Implant any type	YES □ NO □
Other_____	YES □ NO □

OTHER SYSTEMIC:

Hepatitis	YES □ NO □
Diabetes	YES □ NO □
Thyroid Problems	YES □ NO □
Kidney Disease	YES □ NO □
Dialysis	YES □ NO □
Bladder Problems	YES □ NO □
Arthritis/Joint Deformity	YES □ NO □
Artificial Joint	YES □ NO □
Convulsions	YES □ NO □
Epilepsy, Seizures	YES □ NO □
Fainting	YES □ NO □
Depression/Anxiety	YES □ NO □
HIV	YES □ NO □

GASTOINTESTIONAL

Stomach disorders	YES □ NO □
Nausea, Vomiting, Diarrhea	YES □ NO □
Trouble taking antibiotics	YES □ NO □
Ulcerative colitis	YES □ NO □
Crohn's disease	YES □ NO □
Yeast infection when taking antibiotics	YES □ NO □

ALLERGY

To adhesives	YES □ NO □
Latex	YES □ NO □
Get Hives	YES □ NO □
Antibiotic Ointment	YES □ NO □

List any other diseases or conditions_____
List surgeries:_____
_____

List your MEDICATIONS or provide list (include Over The Counter and Herbal Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ Do you give us permission to collect information from any pharmacy or your insurance company regarding any or all of your prescription drug history?
(Initial)

List your medication ALLERGIES and your reaction to them:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SKIN:

Have you had skin cancer? YES □ NO □
If yes, what kind and when:_____
_____
History of skin disease YES □ NO □
If yes, what kind and when: _____
_____
Do you have a history of abnormal moles: YES □ NO □

Family History of skin cancer? YES □ NO □ Do you have problems healing? YES □ NO □
Do you get Keloid/Thick scars? YES □ NO □ Do you bleed easily? YES □ NO □
Skin "pre" cancers ("AKs") YES □ NO □ Psoriasis? YES □ NO □
Seasonal Allergies? YES □ NO □ Eczema? YES □ NO □
Do you get rashes from: Food □ Medication □ Environment □ Ointments □ Other □ _____
Do you take blood thinners?_____ Name_____

FAMILY HISTORY:

Have any of your blood relatives ever had skin cancer? YES □ NO □ _____
If yes, what kind:_____
Have any of your relatives died of skin cancer or a skin related illness? YES □ NO □ _____
Have any of your relatives had any type of cancer? YES □ NO □ What type: _____
Do any of your relatives have a skin condition or disease? YES □ NO □ _____

SOCIAL HISTORY: Do you drink alcohol YES □ NO □ How many per day_____ per week_____
Marital Status_____ # of Children_____
Occupation_____ Hobbies_____

TOBACCO USE: □ Former smoker (how much) _____ < 10 per day_____ > 10 per day
□ Current some days smoker (how much) _____< 10 per day_____ > 10 per day
□ Current everyday smoker (how much)_____< 10 per day_____> 10 per day
□ Never Smoked

Women) Are you pregnant? YES □ NO □ Due Date:_____/_____/_____ Breastfeeding YES □ NO □

_____ Date_____
Patient Signature

_____ Date_____
Provider Signature