

**Mid-Kansas Dermatology
Clinic, P.A.**

PLEASE COMPLETE ALL INFORMATION FULLY (please print)

PATIENT NAME

Last _____ First _____ Middle Initial _____

ADDRESS _____
Street City State/Zip Code Home Phone

Occupation _____ Employer _____ Work Phone _____

Date of Birth _____ Age _____ Sex _____ Cell Phone _____

S.S. # _____ Nickname _____ E-mail _____

Minor _____ Single _____ Married _____ Widow _____

Spouse's Name _____ Employer _____ Work Phone _____

Has patient ever been seen at our clinic before? No Yes (If "Yes" and your name has changed, please indicate former name) _____

IF PATIENT IS A MINOR OR DEPENDENT

FATHER'S NAME Last _____ First _____ Initial _____

ADDRESS _____
Street City State/Zip Code Home Phone

Occupation _____ Employer _____ Work Phone _____

MOTHER'S NAME Last _____ First _____ Initial _____

ADDRESS _____
Street City State/Zip Code Home Phone

Occupation _____ Employer _____ Work Phone _____

Lives with both parents _____ Lives with mother _____ Lives with father _____ Other _____

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

_____ If I choose not to accompany my minor child or dependent to his/her follow-up appointments, I authorize Dr. Passman or his appointee to perform the treatments and/or procedures necessary to deliver appropriate healthcare. I understand this will include evaluation and management for the presenting problem. I understand it may also include prescription of medication, application of Liquid Nitrogen, as well as other minor acne and wart treatment procedures.

_____ I will accompany my minor child or dependent to his/her follow-up appointments. I understand if I do not accompany him/her, he/she will not be seen.

INSURANCE AUTHORIZATION AND PAYMENT POLICY

Primary Insurance _____ Secondary Insurance _____

Policy Holder _____ Policy Holder _____

His/Her SS # _____ D.O.B. _____ His/Her SS # _____ D.O.B. _____

Relationship to Patient _____ Relationship to Patient _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to the Mid-Kansas Dermatology Clinic, P.A. and/or the assigned physicians for the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to said physician and/or surgeon for those services. I understand I am financially responsible for charges not covered by my insurance.

Authorized Signature: _____

Date: _____

INSURANCE INFORMATION RELEASE AUTHORIZATION: I hereby authorize the Mid-Kansas Dermatology Clinic, P.A. and/or the assigned physician to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company.

Authorized Signature: _____

Date: _____

PATIENT NAME _____

AGE _____

APPOINTMENT TIME _____

Referring Doctor _____

City _____

Phone _____

Are you self-referred? _____

Referred by family/friend _____

Family Doctor _____

City _____ Phone _____

WHAT IS/ARE YOUR PROBLEMS (rash, growths, warts, acne, eczema, etc) AND WHEN DID YOU FIRST NOTICE IT?

1st Problem _____ First Noticed _____

2nd Problem _____ First Noticed _____

3rd Problem _____ First Noticed _____

4th Problem _____ First Noticed _____

ARE YOU ALLERGIC TO ANY MEDICINES? (PENICILLIN, ASPIRIN, ETC) YES NO

IF YES, PLEASE LIST _____

FOR WOMEN: ARE YOU PREGNANT? YES NO

IF YES, ESTIMATED DUE DATE _____

PLEASE LIST YOUR PRESENT MEDICAL ILLNESSES: 1. _____

2. _____ 3. _____

4. _____ 5. _____

PLEASE LIST ALL PILLS, MEDICINES, OR TABLETS YOU ARE TAKING (PRESCRIPTION AND NON-PRESCRIPTION):

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

MEDICARE PATIENTS ONLY

YES NO

1. Is the patient a Veteran? _____

a. Did the VA refer the patient here for treatment? _____

b. Does the patient have a VA "fee basis ID Card? _____

2. Does the patient have a Federal Black Lung Card? _____

3. Is this medical condition due to an accident of any kind? _____

If yes, was it: Work Related Auto Injured in own home Other

4. Is the patient covered by a health insurance plan through their own current employment or that of a family member? _____

(Not retiree coverage)

(Information obtained in questions 5 through 7 should be used when coding your claim for Medicare.)

5. Is the patient employed? _____

If "no": Did the patient retire in the last two years? _____

If "yes", give date of retirement: _____

6. Is the spouse employed? _____

If "no": Did the spouse retire in the last two years? _____

If "yes", give date of retirement: _____

7. Please circle the reason patient is Medicare eligible:

Age 65 or Over

Disabled

End Stage Renal Disease (ESRD)

ESRD Effective Dates: (The month kidney dialysis began)

Part A _____

Part B _____