

**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?**

1<sup>st</sup> Problem \_\_\_\_\_ First Noticed \_\_\_\_\_ 2<sup>nd</sup> Problem \_\_\_\_\_ First Noticed \_\_\_\_\_

3<sup>rd</sup> Problem \_\_\_\_\_ First Noticed \_\_\_\_\_ 4<sup>th</sup> 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 \_\_\_\_\_