Broome Nurse Practitioners
SKINCARE

Patient Intake Form

Date: _____

Patient Name: _____ **Date of Birth** _____
(As it appears on your insurance cards)

Gender: Male/Female

Mailing Address: _____
Street (Apt # or Floor)

_____ _____ _____
City State Zip Code

Telephone Numbers: _____ _____(Home/Cell/Work)

Cell Phone Carrier: _____

Email Address: _____

Race: ☐White ☐Black African American ☐Other _____☐ Patient Declined/Unknown

Ethnicity: ☐Spanish/Hispanic ☐Not of Spanish/Hispanic origin ☐ Patient Declined/Unknown

Languages: ☐English ☐Spanish ☐Other ☐Patient Declined/Unknown

Referring Physician: _____ **Telephone:** _____

Primary Care Physician: _____ **Telephone:** _____

How did you hear about us? _____

Pharmacy Name: _____ **Address:** _____

Mail order Pharmacy: _____

Pharmacy Identification Numbers:

RX GROUP #: _____ **RX BIN #:** _____ **RX PCN#:** _____

Primary Insurance Information:

Insurance Company: _____

Insurance identification number: _____

Subscriber's Name: _____ **Date of birth:** _____

How would you like to receive appointment reminders?
(check all that apply)

□ **Home Telephone** □ **Cell Phone-Voicemail**

□ **Email Reminder** □ **Cell Phone- Text Message**

<u>May we leave medical information on? (check all that apply)</u>

□ **Answering Machine** □ **Cell Phone**

□ **Work Voicemail** □ **Send through mail**

□ **Send through secure email** □ **With another person**

I hereby give my permission to release information regarding my care and protected health information to the following individuals:
(Parent, other family members, friends, or others who need to know about your health care).

Name	Relationship	Contact Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ I have received and reviewed the HIPAA statement.

_____ _____
Signature of patient or guardian Date

<u>Please consider joining our educational and promotional email list!</u>

*If email was provided, would you like to receive educational and promotional emails from us? □Yes □No

Authorization For Treatment and Responsibility of Account

*It is your responsibility to supply current insurance cards at every visit.
*If you do not have insurance or cannot provide proof of insurance at the time of service, you will be treated as self- pay and payment in full will be required at time of service.

*We accept cash, checks, and credit cards. A $25 fee will be assessed for returned checks.

*No-show appointments/cancellations less than 24 hours in advance may be charged a $25 fee.

* If your insurance requires a referral from your Primary Care Provider (PCP) to see another physician, it is your responsibility to obtain a referral/authorization prior to your appointment.

* If you are here for multiple procedures. We cannot guarantee multiple procedures on the same day of service. Your insurance company may have one co-payment for the office visit and a second co-payment for the actual procedure.

*All procedures (such as biopsies, liquid nitrogen/freezing, benign removals, skin tags, etc.) are billed separately and are not included in the office visit.

* We will submit claims to your insurance carrier for you. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your plan. Patients are responsible for knowing the details/rules of their health plan(s), as we cannot change our coding to obtain payment.

* I hereby authorize Broome Family Nurse Practitioners to release any medical information required in the course of examination and treatment to allow direct payment to them for services rendered.

*I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine medical benefits or the benefits payable for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, co-insurance, deductible, and non-covered services.

* I give permission to access my pharmacy benefits data electronically through Sure Scripts for the purpose of sending my prescriptions, determining if my health plan allows for electronic prescribing to mail order and if so e-prescribe, allow access to download a historic list of all my medication prescribed to me by any other provider.

*The adult accompanying a minor to a visit and the legal parents/guardians are responsible for any payments due at time of service. We will not be involved in negotiating between parents in custody disputes.

Responsible Party for the Account: (If you are not responsible for your account, please indicate who is)

Name: _____ DOB: _____ Relationship: _____

Mailing Address _____Telephone: _____

*****I have read, understood, and agree to the Financial Policy (above)*****

_____ _____
Name of Patient or Responsible Party (Please Print) Date

_____ _____
Signature of Patient or Responsible Party Relationship to Patient Date

Dermatology Medical History Form

Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Please circle any medical conditions that apply:

Pacemaker
Defibrillator
Asthma
Hay Fever
Seasonal Allergies
Eczema
Psoriasis
High Cholesterol
High Blood Pressure
Stroke
Heart Attack
Congestive Heart failure
Heart Murmur
Heart Valve Problem
Acne
Thyroid Disorder
Kidney problems
Arthritis
Artificial Joints
Liver Cirrhosis
Liver Problems: Type_____
Bleeding disorder
Anxiety
Depression
Pregnant
Breast Feeding
Planning Pregnancy
Gallbladder Removed
Appendix Removed
Hysterectomy: Total or Partial
Tubal Ligation
HIV or AIDS

Hepatitis (Please Circle): A B C

Diabetes controlled by (Please Circle): Diet Medication Insulin

Prone to Yeast Infections with Antibiotics? Yes No

Do you take antibiotics before dental procedures due to a heart murmur, heart valve or artificial joint? Yes No

PERSONAL HISTORY:

Melanoma: If yes, Where _____ When _____
Basal Cell: If yes, Where _____ When _____
Squamous Cell: If yes, Where _____ When _____

Surgeries: _____ Date**:** _____H**ospitalized:** Y/N
_____ Date: _____ Y/N
_____ Date: _____ Y/N

FAMILY HISTORY: Please tell us which of your family members may have had any of these conditions.

Melanoma _____ Breast Cancer_____
Basal Cell Carcinoma _____ Psoriasis _____
Squamous Cell Carcinoma _____ Acne _____
Asthma _____ Allergies _____

SOCIAL HISTORY:

Do you smoke or use tobacco? YES / NO How many per day? _____

Are you a Former Smoker? YES / NO

Do you drink alcohol? YES / NO How many per week? _____

Skin type: Exposure to the sun, without sunscreen would you (please circle)

Always Burn Sometimes Burn Never Burn Always tan

Medications

Please list your current medications, supplements, and vitamins:
Please include dose and frequency.

_____
_____
_____
_____
_____
_____
_____
_____

Allergies

Please list all allergies:

_____
_____
_____
_____
_____
_____
_____

Are you registered with Lourdes or UHS financial assistance program? Y or N

Specimen Lab Processing Policy

Some insurance plans require your specimens be processed by a specific laboratory to avoid out-of-network charges. **Patients that have insurance coverage through employers like Lourdes, UHS, and Guthrie should send specimens to their respective employer's laboratory to avoid any Additional fees. We would advise sending your specimens to ProPath as they have a team of Dermatopathologists (pathologists trained to read skin specimens). No laboratories in the area have Dermatopathologists on site. Due to this, your specimen may be sent out for further testing. This may result in more cost to you and a longer wait-time on pathology results.**

Please provide the laboratory name of your choice below:
If no laboratory is identified, your specimen will be sent to **ProPath.** You will be responsible for any copays, coinsurances or deductibles that result in the processing of your specimen by this ProPath.

Lab:_____