

New Patient Form

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Jack Saunders, PA-C

Date: _____ Patient Name: _____ Gender: M F DOB: _____

Pharmacy: _____ Primary Care Physician: _____

What are you being seen for today?

1. _____
2. _____

Medications currently taking (If numerous, please provide us with a copy of your list):

Have you ever had **skin cancer**? Yes No If yes, what type? _____

Over the years has your sun exposure been: (*please circle one*) Mild Moderate Excessive

Social History

Marital Status: Single Married Widowed

Are you Pregnant or Nursing? Yes No

Do you use tobacco? Yes No

Family History

History of **skin cancer**? Yes No If yes, who and what type? _____

Review of Systems

How are you feeling today? Feeling Well Feeling Fair Feeling Poorly

Do you have allergies/reactions to medications? Yes* No

*If Yes, what medication(s) and symptom(s)? _____

Are you allergic to Band-Aids or tape? Yes No

Difficulty with wound healing? Yes No

Prone to large scars/keloids? Yes No

Prone to infection? Yes No

Bleeding Problems Bleed easily N/A

Lumps under skin (*nodes*) Neck Armpits Groin N/A

Eyes Grittiness Dry N/A

Psychological Anxiety Depression N/A

Musculoskeletal Joint pain swelling N/A

Head Headache Dizziness N/A

Sensitive Stomach (*to pills*) Yes No

OTHER SKIN PROBLEMS Yes No

YOUR Current & Past Medical Conditions

Defibrillator or pacemaker Yes No Arthritis Yes No

Artificial heart valve Yes No Heart disease Yes No

Joint replacement Yes No Neurological disease Yes No

Organ transplant Yes No Liver disease Yes No

HIV infections Yes No Kidney disease Yes No

Hepatitis B or C Yes No High blood pressure Yes No

Diabetes Yes No Bleeding disorder Yes No

Important Billing Information

If you have a harmless growth (such as brown spots or other benign growths) we are happy to treat them but insurance is NOT likely to cover these, as they may be considered “cosmetic”.

If we treat something that is precancerous or cancerous those are not considered cosmetic but depending on your insurance YOU MAY HAVE TO MEET A DEDUCTIBLE BEFORE INSURANCE WILL PAY FOR A PROCEDURE.

If we biopsy or remove a suspicious growth we will send it to the pathologist to determine the diagnosis. As a result, you may also get a bill from the pathologist if you have not met your deductible.

I understand the billing process for the procedure(s) I am undergoing.

Print Patients Name: _____

Patient's Signature: _____
(If patient is a minor, the signature of the guardian)

Date: _____

FOR OFFICE USE ONLY

Patient account #: _____

Witness Signature: _____

Missed Appointment & Late Cancellation Policy

Granger Medical Dermatology values all of our patients and their needs.

Our goal is to provide exceptional care to all of our patients in a timely matter. If you find that you are unable to attend your appointment, a 48-hour cancellation notice is required.

This requirement allows our office adequate time to coordinate care for another patient.

Please be aware that we do charge a \$50.00 missed appointment and or late cancellation fee.

I _____ have read this policy and understand that I will be responsible for a \$50.00
(Please print name)

fee if I fail to call and cancel or no show my scheduled appointment. I ask that a copy of this policy be made so I can keep one for my records at home.

Yes _____ No _____

Patient Signature

Date

(If patient is a minor) Legal Guardian Signature _____

FOR OFFICE USE ONLY

A copy was made by _____ and given to the patient.

Employee Signature

Date

Patient Account #: _____

Patient Registration Form

Patient Information (Please print)

Patient legal name: _____ Gender: Male Female Other
Last name First Name MI Maiden

Mailing address: _____ Marital status: Single Widowed
Street City State Zip

Home phone: _____ Preferred contact method: Married Divorced
 Work phone: _____ Home Work Date of birth: ____/____/____

Cell phone: _____ Cell Text Email SSN#: _____

Email address: _____ *In accordance with federal guidelines, please indicate the following:

Employment: Not employed Employed: _____ Preferred language: If not english _____

Referring provider: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino

Primary care provider: _____ Race: American Indian or Alaska Native Asian
 Black or African American White

Preferred pharmacy: _____ Native Hawaiian or Pacific Islander Other Race

Address: _____ Phone: _____

Do you have a Living Will? Yes No Do you have an Advanced Directive? Yes No

Would you like access to your health information online through our healow app/patient portal? Yes No

How did you hear about us? _____

Responsible Party

Name: _____ Phone: _____
 Relation to patient: _____

Parents of Patient

Father's name: _____ Mother's name: _____
 Home address: _____ Home address: _____
 Phone: _____ DOB: _____ Phone: _____ DOB: _____
 Employer: _____ Employer: _____

Insurance Information
Primary Insurance

Insurance company: _____
 Subscriber's name: _____
 Subscriber's date of birth: _____
 Subscriber's ID#: _____
 Group #: _____
 Patient's relationship to subscriber: _____

Secondary Insurance

Insurance company: _____
 Subscriber's name: _____
 Subscriber's date of birth: _____
 Subscriber's ID#: _____
 Group #: _____
 Patient's relationship to subscriber: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____
 Address: _____

****PLEASE PROVIDE YOUR INSURANCE CARD AND INFORMATION AT CHECK-IN****

FORM CONTINUES ON NEXT PAGE

Medical Information Release to Assigned Parties

In my absence, I authorize Granger Medical Clinic to release all or portions of my, or my dependents, medical record(s) to those as indicated below (i.e. lab results, prescriptions, etc.). This authorization is in effect until I revoke it in writing. Please consider others who may bring your children in for care, such as a relative or guardian.

Name: _____ Relationship: _____ Guardian: _____

Medical release and consent to treat

Phone: _____

Name: _____ Relationship: _____ Guardian: _____

Medical release and consent to treat

Phone: _____

Patient (If 18 years or older) or Parent/Legal Guardian Signature: _____ Date: _____

Consent for Treatment, Release of information, & Assignment of Benefit

I hereby consent to medical treatment, diagnostic tests, laboratory or other procedures, which the physician(s) or other health care provider(s) of Granger Medical Clinic may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing. By signing below, I authorize Granger Medical Clinic to disclose my protected health information, the release of medical information to process my claim(s). As a courtesy to our patients, will file the claim with their insurance carrier with the understanding that the patient/guarantor, not his/her insurance company, is responsible for payment of this account.

Patient (If 18 years or older) or Parent/Legal Guardian Signature: _____ Date: _____

Notice of Privacy Practices

I acknowledge that I have received a copy of Granger Medical Clinic's NOTICE OF PRIVACY PRACTICES and that it is my responsibility to read said notice to understand how my or my child(ren)'s Protected Health Information (PHI) may be used.

I understand that no authorization is required from me in order for Granger Medical Clinic to use my or my child(ren)'s PHI for purposes of treatment, payment, or health care operations. Other uses or disclosures may require my written authorization.

Patient (If 18 years or older) or Parent/Legal Guardian Signature: _____ Date: _____

Notification of Appointments/Treatment/No Shows

Thank you for respecting the time we have reserved for you by providing at least a 24 hour notice, should you need to cancel or reschedule. For no show visits, please be advised that you may be assessed a No Show fee for missed appointments - some may be charged at the cost of the visit or service. If recurrent no shows become an issue, a deposit may be required to hold future appointments. Patients will receive a courtesy text, voice, and/or email reminder, sent out prior to your appointment. Whether received or not, please be advised that it is the patient's responsibility to remember their appointment date and time.

Credit and Finance Charge Policy and Agreement

I agree to provide accurate updated insurance and personal demographic information each visit. I agree to be financially responsible for costs incurred (in my, or my dependent's care). I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by Granger Medical Clinic on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to Granger Medical Clinic (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

All delinquent accounts may be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 33% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees in addition to the collection fee.

You authorize us to call you at any number you provide or at any number at which we reasonably believe we can contact you, including calls and/or text messages to mobile, cellular, or similar devices for any lawful purpose. You agree to any fee(s) or charge(s) that you may incur for incoming calls and/or text messages from us, and /or outgoing calls to us, to or from any such number, without reimbursement from us.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of Granger Medical Clinic's financial policy and agree to pay for said medical services according to such terms.

Patient (If 18 years or older) or Parent/Legal Guardian Signature: _____ Date: _____