GRANGER MEDICAL CLINIC | *Dermatology*

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New Patient Questionnaire

Patient Name: _____ Today's Date: _____
DOB: _____ Gender: ☐ Male ☐ Female
Primary Care Provider: _____
Preferred Pharmacy: _____

What are you being seen for today? _____
_____
_____
_____

Current Medications (if numerous, please provide a copy of your list unless it's already in our system)**:**
_____
_____

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

Has your occupation required that you work outside? ☐ Yes ☐ No

Social History
Marital Status: ☐ Single ☐ Married ☐ Widowed
Are you pregnant or nursing? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No

Do you have a **FAMILY History** of **Skin Cancer**? ☐ Yes ☐ No If yes, what type? _____
Any family history of other skin problems? ☐ Yes ☐ No
If yes, please describe: _____

Review of Systems
Medication Allergies/Reactions: _____
Are you allergic to Band-Aids or adhesive tape? ☐ Yes ☐ No
Are you prone to large scars? ☐ Yes ☐ No
Do you bleed easily/freely? ☐ Yes ☐ No

YOUR Current and Past Medical Conditions
Do you have any of the following?

Defibrillator or Pacemaker	☐ Yes ☐ No
Organ Transplant	☐ Yes ☐ No
HIV/Hepatitis B/Hepatitis C	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No

Please list any other health issues that we should know about: _____
_____
_____

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Acct. #: _____ Deductible: $_____

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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: _____

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Patient account #: _____

Witness Signature: _____

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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 _____

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A copy was made by _____and given to the patient.

_____ _____

Employee Signature Date

Patient Account #:_____

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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

Preferred pharmacy: _____ ☐ Black or African American ☐ White

Address: _____ Phone: _____ ☐ Native Hawaiian or Pacific Islander ☐ Other Race

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, Releast 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:_____