

Patient Information Form

Name: _____
(First name) (Last name) (Occupation)

Address: _____ City _____ Apt _____ State _____ Zip _____

Home Phone: _____ **Cell Phone #** _____

Work Phone: _____ **Marital Status:** _____

Social Security # _____ **Age:** _____ **Sex:** _____ **Birthdate:** / /

Employer's Name: _____

Pharmacy Name: _____ **Pharmacy #** _____

E mail address: _____

Emergency Contact Name/Address: _____

Emergency Contact Phone: _____

Insurance Information/ Medicare Information:

Medicare #: _____ **Insurance:** _____

Insured's Name Policy/Group _____

Insurance Address: _____

Insurance Phone# _____ **Policy #** _____

Group Name/Number: _____

Medical Information: Are you allergic to any medications? _____

Referred by? _____

Reason for this visit? _____

I consent to the performance of certain necessary tests and medical procedures during the course of study, diagnosis, and treatment of my condition as recommended and explained to me by my physician. I consent to the release of medical records to my insurer and other networks. If we accept your health insurance, we will send claims for services rendered. Patients are responsible for payment (some in advance) for deductibles, co-pays, co-insurance, denied claims, terminated policy, non-covered service etc.... Certain financial arrangements can be pre-arranged for payment of bills. Please inform us of your health insurance i.e.: PPO, HMO, Medicare plan before your office visit. Medical emergencies or any other unforeseen circumstances may prevent Dr. Bellman from keeping scheduled appointments. I understand that I am responsible for payment when services are rendered unless prior arrangements have been made. I agree that should my account be referred to an agency or attorney for collection that I will be responsible for all collection costs, attorney's fees and court costs. (10/27/16)

Signature: _____ **Date:** _____

Betty Bellman M.D., P.A.
Patient Medical History Form (Updated 11/09/04)

1) Do you have any allergic reactions to medicine or local anesthetics such as Penicillin, or Novocaine? () yes () no

2) Are you presently in good health?
() yes () no

3) Do you have any respiratory problems?
() yes () no

4) Do you have any heart disease such as a history of irregular heart beats (arrhythmia's), heart attack, heart murmur, chest pain, high blood pressure?
() yes () no

5) Have you ever had cosmetic surgery ?
() yes () no

6) Do you have any kidney, urinary, or prostate problems? () yes () no

7) Are you currently taking any medications and if yes, please list them () yes () no

8) Do you have a history of diabetes and/or thyroid gland disease? () yes () no

9) Have you ever had a stroke, seizures, headaches, or fainting spells? () yes () no

10) Have you ever had cancer? If so, what type.
() yes () no

11) Do you have a pacemaker?
() yes () no

12) Have you ever had a blood transfusion?
() yes () no

13) Do you have any history of skin problems?
() yes () no

14) Do you develop keloids or thickened scars?
() yes () no

15) Have you ever had a skin cancer?
() yes () no

16) Have you or anyone in your family ever had a melanoma? () yes () no

17) Have you noticed any moles enlarging, bleeding, becoming darker, becoming irritated or changing colors?
() yes () no

FOR WOMEN:

1) Do you have a history of breast cancer ?
() yes () no

2) Do you have a family history of cancer ?
() yes, who? What kind? _____
_____ () no

3) Are you pregnant or nursing? () yes () no

Note: The dermatological examination, which you are about to receive, is not a complete physical examination. It is suggested that you have a complete physical examination periodically by your family physician or internist.

Signature of Patient (Parent or guardian if patient is a minor)

X _____

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete our registration form in full before seeing the doctor.

Payment is a due at the time of service. We accept cash, checks, and credit cards. If needed, a payment plan can be established with prior credit approval.

If you have insurance:

Your insurance, if active, and which we can verify, will pay the doctor directly. We still require that you pay all co-payments, deductibles, co-insurance and charges for non-covered services at the time of service.

If you are a member of an HMO or PPO that requires a referral form from your primary care physician, you are responsible to bring this form with you for your visit.

If you have questions or concerns about your bill, you may speak with the office billing department (305)534-8480.

Missed Appointments:

If you are unable to keep an appointment kindly give 24 hour notice. Please, help us serve you better by keeping scheduled appointments. If you need to cancel or do not show up to your appointment for which ever reason there will be a \$35 fee.

Important Information about Biopsies:

Dermatologist traditionally take a sample (surgical biopsy) of suspicious skin growth or rashes in order that microscopic examination of the sample can be performed, and a diagnosis can be made.

This is to inform you that the work associated with processing each biopsy, preparing slides, microscopically examining the slide, and issuing a report of the resulting diagnosis (together known as surgical pathology) is a distinct and separate service from the biopsy itself, and there will be a separate charge.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns. **ANY CHANGES MADE BY THE PATIENT TO THIS FORM WILL NOT BE LEGALLY BINDING.**

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of responsible party

Date

Witness

Date