

**PATIENT INFORMATION**

Child's Name: \_\_\_\_\_ Home Phone (     ) \_\_\_\_\_  
Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_  
Address \_\_\_\_\_  
Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
S.S Number \_\_\_\_\_ S.S. Number \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Employer \_\_\_\_\_ Employer \_\_\_\_\_  
Work Phone # (     ) \_\_\_\_\_ Work Phone # (     ) \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_  
ID or Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_  
ID or Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

**HISTORY**

Reason for Visit \_\_\_\_\_ Allergies \_\_\_\_\_  
Present Medications \_\_\_\_\_  
Family History of Skin Cancer \_\_\_\_\_  
Referred by \_\_\_\_\_ Family Physician \_\_\_\_\_

I hereby grant authority to the physicians of Bernardo Dermatology Medical Group to administer medical and / or surgical treatment to the above named patient.

Parent/Guardian's Signature \_\_\_\_\_

**OFFICE POLICY**

Payment is your responsibility regardless of insurance coverage. Any services/charges that are considered to be cosmetic or not medically necessary will be the patient's responsibility. We will process claims for insurance carriers our doctors are contracted with after copay and deductibles have been met. For those with dual PPO coverage, we follow the guidelines of the primary contract only. PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR ALL OTHER PATIENTS. I have read and understand the above statements. I agree to comply with the financial policies stated.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Authorization for Release of Medical Records**

The undersigned hereby authorizes Bernardo Dermatology, its associated doctors and agents to release and/or furnish information concerning my past and present medical history and condition to those doctors that I may designate either now or from time to time in the future. This information may be used for diagnosis, treatments, consultations, and all medical purposes consistent therewith. This authorization will remain in effect for a period of one year and continue thereafter from year to year unless terminated in writing. I have a right to a copy of this authorization.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

Please Answer These Questions And Return This Page To The Receptionist

Thank You Please Circle the Correct Answers

1. Allergies to Drugs or Medicines No Yes\_(list) \_\_\_\_\_

2. Allergies to Other Things No Yes\_(list) \_\_\_\_\_

3. Are You Taking Medication Now No Yes\_(list) \_\_\_\_\_

Is There Any Personal History of: (you)

Family History of: (blood relatives only)

4. Hayfever Yes No  
5. Asthma Yes No  
6. Eczema Yes No  
7. Psoriasis Yes No  
8. Skin Cancer Yes No

Hayfever Yes No  
Asthma Yes No  
Eczema Yes No  
Psoriasis Yes No  
Skin Cancer Yes No

If any question on this page reveals information which is private or privileged in any way please skip the question and feel free to discuss it with the doctor in person.

9. Diabetes Yes No  
10. Gout Yes No  
11. Heart Attack Yes No  
12. Stroke Yes No  
13. Abnormal Heart Beat Yes No

Diabetes Yes No  
Heart Attack Yes No

14. Blood Clots Yes No  
15. High Blood Press Yes No  
16. Bleeding Problems Yes No  
17. Gall Bladder Prob. Yes No  
18. Kidney Disease Yes No

19. Stomach Ulcers Yes No  
20. Prostate Trouble(men) Yes No  
21. Cataracts Yes No  
22. Hepatitis Yes No  
23. Anemia Yes No

Hepatitis Yes No

24. Breast Cancer Yes No

25. Have You Ever Had a Blood Transfusion?  
Yes No When (year) \_\_\_\_\_

26. Are you or any member of your family HIV positive? \_\_\_\_\_

27. Do you belong to any known high risk group for developing HIV? \_\_\_\_\_  
HIV testing is available through this office.

28. Approximately When was your last Electrocardiogram \_\_\_\_\_

29. Are You Pregnant? Yes No Not Sure

30. Do You Smoke? Yes No

31. Do You Take Aspirin: Daily As Needed Rarely Never

32. Are you being seen by your doctor for any on-going medical conditions other than those listed above? If so, please describe. \_\_\_\_\_

Thank You



# BERNARDO DERMATOLOGY MEDICAL GROUP

## HIPPA PRIVACY POLICY

*Dear Patient:*

We are committed to respecting your privacy and your confidential health information. However, in order to provide excellent care, it is sometimes necessary to share your health information with doctors or other health care providers who are involved in your care. In order to do so, we need your consent.

It is also necessary to share your health information with your health insurance company or its agents, in order to obtain payment for our services. Once again, we need your consent before we will release such information. If you do not wish to provide this consent, then we will set up your account on a "cash basis" and it will be your responsibility to pay for services at the time rendered.

*Thank you.*

### **AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO DOCTORS OR OTHER HEALTH CARE PROVIDERS**

I hereby authorize Bernardo Dermatology to disclose protected health information to my doctors, their office staffs, and hospitals in which I am a patient in the emergency room or in which I am admitted as a patient. I understand that such information will be disclosed for the purpose of medical care and treatment only.

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_

### **AUTHORIZATION FOR BILLING INSURANCE OF OTHER THIRD PARTY**

I hereby authorize Bernardo Dermatology to disclose protected health information to my health insurance company or other third party payor for the purpose of paying for medical services rendered.

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_

**\*\*\*\*Only sign below if you DO NOT agree to the HIPPA Privacy Policy\*\*\*\***

### **AGREEMENT TO PAY AT TIME OF SERVICES**

I do NOT authorize Bernardo Dermatology to disclose protected health information to my health insurance company or other third party payor. As a result, I understand that Bernardo Dermatology will NOT bill my insurance or other third party. I will pay for services at the time that they are rendered.

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_