

CONFIDENTIAL PATIENT DATA

Patient Name _____ **Birth Date** _____
(first) (MI) (last) Female Male

Address _____ Occupation _____
 City,State,Zip _____
 SS# _____

Home (____) ← **Please check the preferred method of contact**
 Work (____)
 Mobile (____) Providing phone numbers & email address indicates
 Text (____) the practice may contact and leave messages.
 E-mail _____

Emergency Contact

Name _____
 Relationship _____
 Home _____
 Other _____

Responsible Party (if patient is a under 18)

Name _____
 Address _____
 City,State,Zip _____
 Phone (____) _____
 Relationship to patient _____

Spouse _____ Children _____

Primary Care Physician _____

I heard about Dr. Van Dam in/from (choose all that apply):

- www.yourskinforlife.com Insurance Company Doctor referral Internet (google,yahoo)
- Quintessential Barrington Article/Newspaper Word of Mouth _____

Referral

I was referred by (name and relation): _____

Are any members of your family patients of this practice? (names) _____

Financial Policy

Please read carefully. I understand and accept that Van Dam Dermatology & Laser Center, Ltd. accepts CIGNA, BCBS PPO Insurance and Medicare assignment only. For patients with any other Insurance carrier, payment in full is expected at time of service. Co-Pays and deductible amounts for CIGNA and BCBS will be collected at the time of service.

Van Dam Dermatology accepts payment by cash, check or credit card. In the event that an account is referred for collection, the patient/responsible party will be responsible for all fees and costs incurred to achieve collection. Billing statements are sent once per month and only after we have received any applicable insurance benefits. There will be a fee of \$15.00 for the second and third monthly statements. This fee can be avoided by payment upon receipt of your first billing statement. Any balance unpaid with 15 days after the third statement will be considered delinquent.

A charge of \$25.00 will be added to the patient/responsible party account for any check returned by the bank. All "no-show" appointments will be charged a missed-appointment fee of \$50.00. (A "no-show" is an appointment which a patient does not cancel at least 24 hours prior to their scheduled appointment time.) Missed appointment fees are expected to be paid and will not be adjusted off your account.

Health History:

I take these prescription medications: _____

I take/use the following contraceptives or hormone replacement therapy: _____

I take aspirin: Yes No Dose/Frequency: _____

I take the following vitamins/herbal supplements: _____

I have the following allergies (include medications): _____

I have had the following surgeries: _____

I am presently under a doctor's care for the following conditions: _____

Lifestyle & Personal History:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Chest X-Ray | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Extreme Weight Loss/Gain | <input type="checkbox"/> Mitral Valve Problems |
| <input type="checkbox"/> Allergy to <u>Local</u> Anesthetics | <input type="checkbox"/> Faints Easily | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Allergy Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Cancer, family history |
| <input type="checkbox"/> Blood Clot in Leg/Lung | <input type="checkbox"/> Hives | <input type="checkbox"/> Sun Poisoning |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Swelling Foot/Ankle |
| <input type="checkbox"/> Bowel Disorder | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Joint Pains/Arthritis | <input type="checkbox"/> Tuberculosis, positive test |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Keloids/Excessive Scarring | <input type="checkbox"/> Yeast Infections |

I have the following medical conditions not mentioned above: _____

I presently smoke or use nicotine: Yes No Amount: _____

I consume alcoholic beverages: Yes No Frequency: _____

Cosmetic Skin Conditions/Concerns (optional):

I am here today because: _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Acne Prone Skin | <input type="checkbox"/> Irregular Moles | <input type="checkbox"/> Melasma |
| <input type="checkbox"/> Aging Skin/Wrinkles | <input type="checkbox"/> Irregular Pigment | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Excessive Perspiration | <input type="checkbox"/> Irregular Vessels/Veins | <input type="checkbox"/> Sun Damaged Skin |
| <input type="checkbox"/> Unwanted Areas of Fat | <input type="checkbox"/> Loss of Facial Fullness | <input type="checkbox"/> Unwanted Hair Growth |

I currently use the following skin care products: _____

I have had the following skin treatments: _____

My signature below affirms my understanding and willingness to comply with the above stated policies. I attest that the following history is completed to the best of my knowledge. I also accept that my failure to fully disclose all health information may adversely affect my safety or the outcome of any treatment prescribed by David P. Van Dam, MD, or any member of his staff, including Van Dam Dermatology & Laser Center and Versa Medi-Spa.

Patient or Guardian Signature _____ **Date** _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I acknowledge that Van Dam Dermatology & Laser Center has the “**Notice of Privacy**” and the “**Red Flag Rule**” policies in the office waiting room for me to review.

Compliance with the “Red Flag Rule” is required by the federal government and is intended to help safeguard against identity theft. The “Red Flag Rule” requires that we obtain a photo ID that confirms you are the person you say you are.

I consent to the use or disclosure of my Protected Health Information (PHI) by Van Dam Dermatology & Laser Center for purposes of Treatment, Payment and Health Care Operations as described in the “Notice of Privacy”.

I understand that this consent remains in effect until I revoke it. I have the right to rescind this consent in writing at any time, but such revocation will not apply to any uses or disclosures that occurred before the effective date of the revocation.

I understand that Van Dam Dermatology & Laser Center will attempt to communicate with me regarding my PHI and that I have the right, at any time, to request restrictions and changes in how my PHI is used or disclosed and how I am contacted by Van Dam Dermatology & Laser Center.

I understand that I must change my preferences in writing by completing the Van Dam Dermatology & Laser Center **Request for Change in Release of Private Health Information** form and forwarding it to the Privacy Office. (You may obtain a form from our receptionist.)

I understand that I have a right to a copy of this consent form.

The **Notice of Privacy Practices** for Van Dam Dermatology & Laser Center is subject to change and revision. If we make any revisions, paper copies of that revision will be available in our office as of the effective date and will also be posted in our waiting room.

I hereby acknowledge all of the above:

Print Patient Name

Signature of Patient or Personal Representative

Relationship of Personal Representative to Patient

Date

For Privacy Issues, please contact:

Van Dam Dermatology & Laser Center
Privacy Officer
738 W. Northwest Highway
Barrington, IL 60010
Phone: 847.382.5111
Fax: 847.382.8993

PATIENT REFUSED TO SIGN_____

Insurance Information Form

Please complete this form and present it, with your insurance card, to our office staff. We are a contracted provider with BCBS (PPO), Cigna and Medicare. If you have any other insurance, our financial policy requires your payment at the time of service. As a courtesy to you, we will be happy to file your claim.

Patient's Information (Please Print)

Patient's Name _____

Today's Date _____

Patient's Date of Birth _____

Patient's Social Security # _____

Is the insurance in your name? Yes No

If you answer "Yes" to this question there is no need to continue

Primary Card Holder Information

Patient's relationship to policy holder: Self Spouse Child Other
(For example; The patient is the child of the primary card holder)

Primary Card Holder:

Name _____

Address _____
(If different than patient)

Date of Birth _____ Male Female

Social Security # _____ (If available)