Dermatology of Central Ohio

Patient Information Forms

Dr. J. Michael Holsinger, DO
Vera Smith, PA-C

Patient:

Last name: ____________________ First Name: ____________________

Middle initial: ________ Jr., II: ________ Maiden name: ____________________

Address: ____

City: ____________________ State: __________ Zip: ____________

Primary Phone #: ____________________ Secondary Phone #: ____________________

Date of Birth: ______________ Age: ____ Male Female Social Security #: ____________________

Marital Status: Single Married Divorced Widowed Separated Email: ____________________

Referring Physician: ____________________ Primary Care Physician: ____________________

Responsible Party: Self Parent Spouse Other (Fill out below if other than Self)

Name: ________________________________ Date of Birth: ______________

Address: ____

Phone #: ____________________ Social Security # ____________________

List of approve people that we can speak with regarding your medical information

It is the office policy of Dermatology of Central Ohio to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian of a minor, (II) other persons authorized by patient, (iii) as we may reasonably infer from circumstances (for example, you being a family member or friend into the exam room, we assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information to be discussed with anyone, please leave blank.

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

Emergency Contact Information: Name: ____

Number: ____________________ Relationship to patient: ____________________

By signing below, I hereby (i) acknowledge receipt of Dermatology of Central Ohio's Notice of Privacy Practice, (ii) authorize the above listed people to receive information regarding my treatment or care, and (iii) certify that the above information is correct to the best of my knowledge.

Print: ____________________________ Sign: ____________________________

Date: ______________ Relationship to the patient: ____________________________

For patients 65 and older:

Do you have an Advanced Directives/Living Will? YES NO

Do you have a durable power of Attorney for healthcare or healthcare proxy? YES NO

POA Name: ____________________________ Number: ____________________

Dermatology of Central Ohio

Financial Policy

Dr. J. Michael Holsinger, DO
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Thank you for choosing us as your dermatology care provider. We are committed to providing you with the best possible medical care. Please understand payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign.

BILLING INSURANCE

•It is very important that we receive the correct insurance information. Please bring your insurance card(s) with you to each visit and remember to update the office of any demographic changes (address, phone number, etc.)

•Prior to your appointment in our office, please check if care by our physician or physician assistant is covered by your health plan and to learn about your plan's covered services, payment terms and referral policy.

•All office copays are due at the time of service.

•Regardless of your insurance coverage, you are responsible for payment for the services performed. We will be happy to submit a claim to your insurance carrier. If you are unable to show proof of coverage, we expect payment for services at the time of your office visit.

BILLING FOR SERVICES

•This office charges for all services that are significant and separately identifiable. Patients that are seen for full skin exams and have any other treatments will be charged separately for each service even when both services provided on the same day.

•All balances are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject to our collection process.

•For any procedures deemed "cosmetic procedures" payment is due at the time of service. Accepted payment is cash or credit card. If you elect to have a cosmetic procedure done along with another service, for example a full skin exam, we will submit the non-cosmetic charges to your insurance for all services that are significant and separately identifiable. These charges will be charged separately for each service even when both service are provided on the same day.

MISSED APPOINTMENTS

•There will be a fee charged for all appointments that were not kept and/or cancelled 24 hours prior or the appointment time. An exam appointment is $25 and a surgical appointment is $50. Appointments are in high demand, and your early cancellation will give another person the possibility to make that appointment.

•If you miss or no show for three (3) appointments and/or are non-compliant you may be dismissed from the practice.

•If you are 15 minutes late for your appointment you may be billed for a no show appointment and be asked to reschedule.

RETURNED CHECKS

•There is a $35.00 fee on all returned checks.

I have read the Financial Policy above. I understand and agree to the terms. I verify that the billing information I have provided is accurate and authorize release of any medical information necessary to process claims.

Print: ____

Sign: ____

Date: ______________ Relationship to Patient: ________________________________

Dermatology of Central Ohio

History and Intake Forms

Dr. J. Michael Holsinger, DO
Vera Smith, PA-C

Date of Birth: ________________

Past Medical History: (please check all that apply)

Anxiety	Diabetes	Lung Cancer
Arthritis	End Stage Renal Disease	Lymphoma
Asthma	GERD	Prostate Cancer
Atrial Fibrillation	Hearing Loss	Radiation Treatment
Bone Marrow Transplant	Hepatitis	Seizures
Breast Cancer	High Blood Pressure	Stroke
Colon Cancer	HIV/AIDS	Thyroid Problems
Coronary Artery Disease	High Cholesterol	
Depression	Leukemia	****NONE****

Other: ____

Past Surgical History: (please check all that apply)

Appendix Removed	Biological Valve Replacement	Ovaries Removed: Endometriosis
Bladder Removed	Heart Transplant	Ovaries Removed: Cyst
Mastectomy (right, left, bilateral)	Joint Replacement within 2 years	Ovaries Removed: Ovarian Cancer
Lumpectomy (right, left, bilateral)	Joint Replacement Knee	Prostate Removed: Cancer
Breast Biopsy (right, left, bilateral)	(right, left, bilateral)	Prostate Biopsy
Breast Reduction	Joint Replacement Hip	TURP (Prostate Removal)
Breast Implants	(right, left, bilateral)	Spleen Removed
Colectomy: Colon Cancer Resection	Kidney Biopsy (nephrectomy)	Testicles Removed (right, left, bilateral)
Colectomy: Diverticulitis	Kidney Removed (right, left)	Hysterectomy (fibroids)
Colectomy: IBD	Kidney Stone Removal	Hysterectomy (Uterine Cancer)
Gallbladder Removed	Kidney Transplant	****NONE****

Other: ____

Skin Disease History: (please check all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itching Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	****NONE****

Other: ____

ALERTS: (please check all that apply)

Allergy to Adhesive

Allergy to Lidocaine

Allergy to Topical Antibiotics

Artificial Heart Valve

Artificial Joint Replacement

Taking Blood Thinner

MRSA Pacemaker

Require Antibiotic prior to surgical procedures

Rapid Heartbeat with Epinephrine

Are you pregnant or trying to get pregnant?? YES NO

Have you had a FLU SHOT within the last year? YES NO

Have you had a PNEUMONIA vaccine? YES NO

Do you have a **DEFIBRILLATOR** or **PACEMAKER**?? (please circle)

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Medications: (please list all current medications, including vitamins and supplements)

Allergies: (please list all allergies, including medications, foods, etc)

Family Health History: (please list any health disease history of first degree relatives - Mother, Father, Siblings, Children)

Do you wear Sunscreen? YES NO If yes, what SPF? __________

Do you tan in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO If yes, what relative? MOTHER FATHER BROTHER SISTER CHILD

Social History: (please check all that apply)

Cigarette Smoking:	Alcohol Use:
Currently Smokes	Less than one drink per day
Never Smoked	1-2 drinks per day
Former Smoker	3-4 drinks per day
Vapes	NONE

Primary Care Physician: ____

Preferred Language: ____

Race: (check) Caucasian Hispanic African-American Other: ___________________________

Ethnic Group: (check) Hispanic Not Hispanic Other

Preferred Pharmacy Name: ____

Pharmacy Phone #: ____

Pharmacy City and/or Zip Code: ____