BAIN Dermatology
Skin Cancer Surgery & Cosmetic Specialists

7200 Creedmoor Road, Suite 104
Raleigh, NC 27613
Phone: (919) 518-0999
Fax: (919) 518-0939
www.baindermatology.com

WELCOME TO BAIN DERMATOLOGY. PLEASE FILL OUT ALL PERTINENT SECTIONS AND SIGN WHERE INDICATED.

****KINDLY PROVIDE YOUR DRIVER'S LICENSE TO THE FRONT DESK****			TODAY'S DATE:
Last Name:			Home Phone#: Check Preferred Contact Number
First Name:	M. I.		Work Phone#: Ext:
Street Address:	Apt#		Cell Phone#:
City: State: Zip:			Date of Birth: Sex (M/F):
E-Mail Address:			Marital Status: Single Married Other
Race:	Ethnicity: Hispanic Non-Hispanic		Employed: Employed Full-time student Part-time student
Preferred Language:			

EMERGENCY CONTACT	
Name:	In addition to the emergency contact listed, I give permission for my medical information to be released to the following individuals as well:
Phone #:	Name:
Do you give our office permission to discuss your medical information with the person listed above? Y E S N O	Name:

REFERRING DOCTOR		PRIMARY CARE PHYSICIAN (If different than referring doctor)	
Last Name:	First Name:	Last Name:	First Name:
Address:	Phone#:	Address:	Phone#:
City:	State: Zip:	City:	State: Zip:

PRIMARY INSURANCE INFORMATION	
Insurance Carrier:	Group Name or Number:
Subscriber ID#:	Copay: Deductible Amount:
Your relationship to the insured person: ___Self __Husband ___Wife __Child __Other	

PRIMARY INSURED PARTY: If the insured party is different from the patient, you must complete all information in the section below.

First Name:	Last Name:	M. I.	Sex: ( )Male ( )Female	
Address:	City:	State:	Zip:	Phone#::
Date-of-Birth:	Insured's Social Security Number:			

SECONDARY INSURANCE INFORMATION	
Insurance Carrier:	Group Name or Number:
Subscriber ID#:	Copay: Deductible Amount:
Your relationship to the insured person: ___Self __Husband ___Wife __Child __Other	

SECONDARY INSURED PARTY: If the insured party is different from the patient, you must complete all information in the section below.

First Name:	Last Name:	M. I.	Sex: ( )Male ( )Female	
Address:	City:	State:	Zip:	Phone#::
Date-of-Birth:	Insured's Social Security Number:			

Name: **Appt Date :**

Height: _____ Weight: _____

PAST MEDICAL HISTORY

Do you have a history of, or currently have, any of these conditions? **Please answer yes or no to all questions.**

Skin:

PreCancer/Actinic Keratosis	Y	N
Melanoma	Y	N
Basal cell carcinoma	Y	N
Squamous cell carcinoma	Y	N
Abnormal moles	Y	N
Other skin condition	Y	N

Cardiovascular:

High blood pressure	Y	N
Artificial heart valve	Y	N
Pacemaker/defibrillator	Y	N
High cholesterol	Y	N
Irregular heart rhythm	Y	N
Heart murmur	Y	N

Endocrine:

Diabetes	Y	N
Thyroid disease	Y	N

Hematologic:

Bleeding disorder	Y	N
Blood clotting disorder	Y	N
Lymphoma or leukemia	Y	N

Immunologic / Infections:

AIDS / HIV disease	Y	N
Hepatitis B	Y	N
Hepatitis C	Y	N
Autoimmune disease	Y	N
History of MRSA / Staph	Y	N
Tuberculosis/positive PPD	Y	N
Immunosuppression	Y	N

Neurologic:

Multiple sclerosis	Y	N
Guillain-Barre syndrome	Y	N
Migraines	Y	N
Parkinson's disease	Y	N
Seizures	Y	N
Stroke	Y	N

Psychiatric:

Anxiety disorder	Y	N
Bipolar disease	Y	N
Depression	Y	N

Respiratory:

Asthma	Y	N
Other lung disease	Y	N

Surgical:

Organ transplant	Y	N
Heart surgery	Y	N
Spinal or brain surgery	Y	N
Artificial joint	Y	N

OTHER:

Any kidney problem	Y	N
Arthritis	Y	N
Glaucoma	Y	N
Inflammatory bowel disease	Y	N
Liver disease	Y	N
Reflux (GERD)	Y	N
Stomach ulcers	Y	N
Internal cancer (non-skin)	Y	N
History of radiation	Y	N
Currently attempting to conceive children	Y	N

Females only:

Hysterectomy	Y	N
Tubal ligation	Y	N
Currently pregnant	Y	N
Currently breastfeeding	Y	N

Current Smoker? Y N

Former Smoker? Y N

If yes to smoking, how much and starting /end dates: _____

Alcohol use? Y N

If yes, # times in past year you drank more than 5 (men) or more than 4 (women)? _____

Date of last flu shot: _____

Date of last pneumonia shot: _____

Tanning bed use? Y N

Sunscreen usage? Y N

If yes, sunscreen used: _____

Prior blistering sunburns? Y N

If yes, # of times and dates: _____

Pharmacy: _____

Allergies: _____

_____

_____

Medications (continue on back of this page if needed):

_____

_____

_____

Occupation? _____

Primary Care Provider: _____

Additional Details / Other: _____

FAMILY HISTORY (please circle):

Melanoma Basal cell cancer Squamous cell cancer Psoriasis Eczema Acne

PATIENT'S NAME (LAST, FIRST):

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol Use:
Currently Smokes	None
Has smoked in the past	Less than 1 drink per day
Never smoked	1-2 drinks per day
Former Smoker	3 or more drinks per day

Family Medical History: (Only first degree relatives)

_____
_____
_____
_____

Cosmetic Dermatology:

Are you interested in discussing any treatments to address fine lines and wrinkles, facial volume loss or any other cosmetic concerns?

Yes ____ No ____

Preferred Language: _____

Race: _____ **Ethnic Group:** _____

Preferred Pharmacy Name: _____

Phone#: _____

City or Zip Code: _____

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The Skin Surgery Center, PA
CONSENT FOR USE OR DISCLOSURE OF INFORMATION
FOR THE TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (HIPAA)

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by the Skin Surgery Center. P.A. in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review The Skin Surgery Center Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such notice prior to signing this consent form.

The Skin Surgery Center reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If The Skin Surgery Center does change the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requisition the Notice from the Front Office Staff of The Skin Surgery Center.

I retain the right to request that The Skin Surgery Center further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Skin Surgery Center is not required to agree to such requested restrictions; however, if The Skin Surgery Center does agree to my requested restriction(s), such restrictions are then binding on The Skin Surgery Center.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to The Skin Surgery Center in writing. The revocation shall be effective *except* to the extent that The Skin Surgery Center has already taken action in reliance on the consent. *The Skin Surgery Center may refuse to treat you, if you do not sign this Consent Form* (except to the extent that The Skin Surgery Center has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals)).

PHONE CONSENT: I AUTHORIZE THE PHYSICIANS AND STAFF OF THE SKIN SURGERY CENTER TO:

Leave a message on my answering machine or voicemail at home	____Yes ____No	Tel# _____
Leave a message on my cell	____Yes ____No	Tel# _____
Text a message to my cell phone	____Yes ____No	Tel# _____
Leave a message at my place of employment	____Yes ____No	Tel# _____
Discuss my medical condition with a member of my family or friend	____Yes ____No	Tel# _____

If yes, please print names: _____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____ Date _____
Signature of Patient Date of Birth

_____
Please Print Name

_____ _____ _____
Signing on behalf of Patient Please Print Name Relationship to Patient

CONSENT FOR MINOR TO PRESENT FOR TREATMENT
(If patient is under 18 – A parent or Guardian must sign)

I, _____, give my consent for my son/daughter, _____ to bring himself/herself to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

Parent's signature _____ Date _____

Witness _____ Date _____

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The Skin Surgery Center, PA

AUTHORIZATIONS AND CONSENTS FOR PRECERTIFICATION, FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND RELEASE OF CLAIMS INFORMATION

Precertification & financial Responsibility: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of appointment.

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to The Skin Surgery Center, (SSC), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorized and direct the insurance company to pay all such benefits to SSC. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and SSC.

Authorization to Release Claims Information: I hereby authorize The Skin Surgery Center, their employees and agents to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits by or on behalf of any such person. I hereby authorize SSC, its employees and agents to act on my behalf in completing claims.

I HAVE READ AND FULLY UNDERSTAND THE PRECERTIFICATION & FINANCIAL RESPONSIBILITY AUTHORIZATIONS, ASSIGNMENT OF BENEFITS COSENTS AND AUTHORIZATION TO RELEASE CLAIM INFORMATION PRINTED ON THIS FORM AND FULLY ACCEPT AND CONCENT TO EACH OF THEM. THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature _____ Date _____

Patient's Printed Name _____

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is as follows:

Signature of Authorized Representative _____

Relationship to Patient _____ Date _____

Witness _____ Date _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ **The patient refused to sign.**
- ☐ **Due to an emergency situation it was not possible to obtain an acknowledgement.**
- ☐ **We weren't able to communicate with the patient.**
- ☐ **Other (Please provide specific details)**

_____
_____

_____ _____
Staff Signature Date