North Baltimore Dermatology

Advanced Dermatology
Bel Air • Hunt Valley • Towson

Advanced Dermatology Bel Air
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Patient Information

Name _____ _____ _____
(Last) *(First)* *(M.I.)*

Preferred Language: _____ Gender: ❑ Male ❑ Female Marital Status: _____

Race: _____ Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown Date of Birth: ____/____/____

Address _____
(Street) *(City)* *(State)* *(Zip Code)*

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____ By providing, you may receive newsletters, updates and specials regarding our office.

Emergency Information

Emergency Contact Name _____ _____
(Last) *(First)*

Relationship _____ Phone: ( ) _____

Physician/Pharmacy Information

Primary Care Physician _____

Preferred Pharmacy/Location/Phone # _____

Insurance Information

Primary Insurance Company _____

Policy #:_____ Group #:_____

Policy Start Date: ____/____/____ CoPay _____ Referral Required? ❑ Yes ❑ No

Policyholder Name _____ Relationship _____
(Last) *(First)*

Date of Birth: ____/____/____ Card Address _____ Phone: ( ) _____

Secondary Insurance Company _____

Policy #:_____ Group #:_____

Policy Start Date: ____/____/____ CoPay _____ Referral Required? ❑ Yes ❑ No

Policyholder Name _____ Relationship _____
(Last) *(First)*

Date of Birth: ____/____/____ Card Address _____ Phone: ( ) _____

Authorization Information

I have read the Privacy Practices document which contains a Health Insurance Portability and Accountability Act of 1996 (HIPAA) notice provided on the Englert Dermatology LLC web site (www.dermteammd.com).

I hereby authorize Englert Dermatology LLC to release any information necessary for my course of treatment. I also authorize the release of medical information to anyone to which they may release billing or patient care information on a regular basis. In addition, I hereby authorize the release of information to personal acquaintances named below (and relationship if possible):

1) _____ Relationship: _____

2) _____ Relationship: _____

I have read the above policy regarding my financial responsibility to Englert Dermatology LLC for providing Dermatology service to the above named patient or me. I certify that the information provided is so, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Englert Dermatology LLC. I agree to pay Englert Dermatology LLC the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____ Date: ____/____/____

We will bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill. You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/ coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue treatment past your approved period, you will be responsible for your account balance in full. (Rev. 1/14/14)

Patient Name _____ **D.O.B.** _____

Primary Care Physician_____

Medication Allergies and what happens?_____

List of Current Medications (OTC and Prescription)	**Reason of Medication**

Medical Conditions Known to the Patient:

Have you ever been hospitalized, if yes, please list dates and problems

Year	Problem/Surgery

Do you have a History of:	**Yes**	**No**
Hepatitis C		
Herpes		
HIV/AIDS		
Hyperthyroid		
Hypothyroid		
Liver Disease		
Lupus		
Acne		
Actinic Keratoses		
Asthma		
Skin Cancer		
Blistering Sunburns		
Dry Skin		
Eczema		
Flaking/Itchy Scalp		
Melanoma		
Precancerous moles		
Psoriasis		

Does Anyone in Your Family have a History of:	**Yes**	**No**
Allergies		
Asthma		
Cancer		
Cancer of the Skin		
Dermatitis		
Eczema		
Melanoma, if so who? _____		
Psoriasis		

Do you have:	**Yes**	**No**
Adhesive Allergy		
Latex Allergy		
Topical Antibiotic Allergy		
Sensitive Skin		
Changing Moles (color, size, bleeding)		
Rashes		
Fever or Chills		
Problems with Bleeding/on Blood Thinners		
Problems with Scarring (keloids, etc.)		
Pacemaker or Defibrillator		
Pregnancy or Planned Pregnancy		
Abdominal Pain		
Blurry Vision		
Chest Pain		
Headaches		
Seasonal Allergies		
Joint/Muscle Aches		
Unexplained Weight Loss/Gain		
Hair Loss		
Nail Changes		
Recent Stress		
Depression		
Artificial Joints in the past two years		

Personal Habits

Do you tan in a tanning salon? _____

Do you use sunscreen, if so what SPF? _____

Do you smoke or have you smoked in the past? _____

Do you have a history of drug use? _____