

**BRYKERWOOD SKIN AND VEIN CENTER
NEW PATIENT INFORMATION**

Date _____
Name _____ Date of Birth _____ Age _____ Sex : M F
Address _____ Apt # _____ City _____ ST _____ Zip Code _____
Daytime Phone _____ Evening Phone _____ Cell/Alternate Phone _____
Social Security # _____ Emergency Contact _____ Phone _____
(Circle One) MINOR SINGLE MARRIED (if married name of spouse) _____

May we discuss medical / billing information about you with your spouse? YES NO

Employer _____ Occupation _____
Primary Care Physician _____ Referred by _____

RESPONSIBLE PARTY

[Who is responsible for the account if different than above]

check if SELF

Name _____ Relationship _____
Date of Birth _____ Drivers License # _____ Social Security # _____
Address _____ Apt # _____ City _____ ST _____ Zip Code _____
Employer _____ Occupation _____
Daytime Phone _____ Evening Phone _____ Alternate Phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE (circle one)

MEDICARE BCBS PPO BCBS HEALTHSELECT PHCS OTHER NO INSURANCE

If OTHER is circled, please give insurance carrier name _____

Policy Holder's Name _____ SS# _____

Policy Holder's Date of Birth _____ Employer _____ Relationship to Patient _____

SECONDARY / SUPPLEMENTAL INSURANCE—YES NO

Insurance Company Name _____ ID# _____ Group # _____

Policy Holder's Name _____ Date of Birth _____ Relationship to Patient _____

DISCLOSURE STATEMENT

If we are in network with your insurance all co-pays, co-insurance and deductibles are due at the time of service. If we are not in-network, then all charges are due and you will be reimbursed directly by your insurance company based on your out-of-network benefits. All cosmetic or non-covered services are also due at time of visit and likely won't be covered by you insurance.

All Medicare claims are filed with Medicare but the 20% that Medicare does not cover will be collected at the time of service until we know that your secondary insurance accepts claims from Medicare directly. If Medicare files your claim with your secondary and they do not pay within 60 days then you will be billed for the balance on the claim. You may pursue reimbursement for these services directly from your insurance carrier.

If you have Blue Cross Blue Shield Health Select, you must have a referral from your Primary Care Physician for every office visit. If one is not obtained by the time of the office visit, you will be required to sign a waiver and pay for 100% of charges as the insurance company will deny coverage without a referral.

I have read and understand the above disclosure and have filled out my insurance information accurately.

Patient / Responsible Party Signature _____ Date _____

Clinic Representative _____ Date _____

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ASSIGNMENT / RELEASE

- I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such medical care to third party payers including Medicare.
- If my insurance is in network, I assign my medical insurance to pay the billed charges. I understand that my medical insurance company may pay less than the billed charges. I agree that I may be responsible for payment of services rendered on my behalf or my dependents.
- I understand I may be billed from an outside laboratory for pathology or lab charges. These services are separate from any procedures done in this office.

FINANCIAL POLICY

- We accept CASH, CHECKS-with valid driver's license, MASTERCARD, VISA and AMERICAN EXPRESS. **There will be a \$25.00 return check fee assessed to patients account for each returned check.*
- If copies of your medical records are needed, we require patients to sign a medical record release. The fee for record copying is \$25.00.
- If you have any balance due from deductibles, co-insurance etc., statements will be sent out monthly. Payment is considered due for the full amount when you receive your statement. Payment plans are not available.
- We require a 24-hour notification prior to cancellations for all appointments. The following are the cancellation fees.

<OFFICE VISIT	\$30
<SURGERY	\$200
<AESTHETIC or COSMETIC TREATMENT	The cost of the procedure.

As a courtesy, we call to remind you of your appointment 48-72 hours in advance. You are still responsible for your appointment, even if we are unable to contact you. Please make sure have updated the numbers where you can be reached.



I have read and understand the above Authorization/Release and Financial Policy.

Patient Name (print) _____ Date _____

Patient / Responsible Party Signature _____ Date _____

Clinic Representative _____ Date _____

**BRYKERWOOD SKIN AND VEIN CENTER
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Patient Name _____ Date _____

PAST MEDICAL HISTORY—Please complete entire section

Do you have, or have you ever had any of the following? (*If yes, please check box and explain in line provided.*)

- | | |
|--|--|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Blood Clots/Phlebitis _____ | <input type="checkbox"/> Irregular Heartbeat _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Joint Replacement _____ |
| <input type="checkbox"/> Defibrillator _____ h/r _____ | <input type="checkbox"/> Kidney problems _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Pacemaker _____ h/r _____ |
| <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Psychological disorders _____ |
| <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Stomach problems _____ |
| <input type="checkbox"/> Headaches/Seizures _____ | <input type="checkbox"/> Thyroid problems _____ |
| <input type="checkbox"/> Heart disease/Heart Attack/Bypass _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Heart Murmur _____ h/r _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis B/C _____ | |
| <input type="checkbox"/> High Blood Pressure _____ | |

Females: Pregnant—**IF NO**, Date of Last Period: _____
 If **NOT**, planning pregnancy, then list method of Birth Control: _____

Have you ever had any Skin Cancer, Melanoma, Atypical or Dysplastic Moles or Pre-cancerous lesions? (*If yes, explain location, diagnosis and when treated*) _____

Are you **ALLERGIC** to any medications? If so, please list _____

What medications are you currently taking? (Include all over the counter medications, herbs and/or vitamins)

SOCIAL HISTORY—Please complete entire section

- Do you drink alcohol? _____ If yes, how many drinks per day/week _____
 Do you smoke or use tobacco products? _____ If yes, how long and how many packs per day _____
 Where did you grow up? _____
 Hobbies / Leisure activities that keep you outdoors _____
 Have you had more than 3 sunburns before age 18? Yes No
 Have you had a sunburn in the last 10 years? Yes No If yes, where on body? _____
 Have you had any blistering or peeling sunburns? Yes No If yes, where on body? _____
 Have you tanned in a tanning bed? Yes No If yes, what age(s) and # of uses. _____

FAMILY HISTORY—Please complete entire section

(Check any medical condition(s) that have occurred in your family)

- | | |
|--|--|
| <input type="checkbox"/> Cancer (other than skin cancer)
Family Member(s) _____ Type of Cancer _____ | <input type="checkbox"/> Skin Cancer
Family Member(s) _____ Type of Skin Cancer _____ |
| <input type="checkbox"/> Atypical /Dysplastic Moles <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malignant Melanoma
Family Member(s) _____ |
| <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis | _____ |
| <input type="checkbox"/> Lupus <input type="checkbox"/> Varicose Veins | _____ |
| <input type="checkbox"/> High Cholesterol | _____ |

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REVIEW OF SYMPTOMS—Please complete entire section

Have you had any problems related to the following organ systems that you have not discussed with another physician?

(Please circle answer. If yes, explain in line provided.)

Allergic/Immunologic	YES	NO	_____
Arthritis/Muscles/Joints	YES	NO	_____
Blood/Bleeding disorders	YES	NO	_____
Ears/Nose/Throat/Mouth	YES	NO	_____
Eyes	YES	NO	_____
Headaches/Seizures	YES	NO	_____
Heart	YES	NO	_____
Kidneys	YES	NO	_____
Lungs	YES	NO	_____
Skin	YES	NO	_____
Stomach/Bowel	YES	NO	_____
Thyroid/Diabetes	YES	NO	_____



Patient / Responsible Party Signature _____ Date _____

Clinic Representative _____ Date _____

Physician Signature _____ Date _____