HULL
DERMATOLOGY & AESTHETICS

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Patient Information must be completed for all patients.

Name:_____ **Date:**_____
Last First Middle

Date of birth:__/__/__ **Gender: M**__**F**__ **Social Security:** _____

Mailing Address: _____
Street City State Zip

Home Phone: _____ **Mobile Phone:** _____

Okay to leave a message: Home __ **Cell**__ **Reason For visit:**_____

Email Address: _____

Referring Provider:_____ **PCP:** _____

Preferred Pharmacy: _____ **Preferred Language:** _____

Would you like to view your information online? Yes____ **No** _____
EX: Request appointment, request refills on prescriptions, view lab results, and ask questions.

Marital Status: Single___ Married___ Divorced____ Widowed_____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined to Specify

Race:

- ☐ Asian
- ☐ Native Hawaiian
- ☐ African American
- ☐ White
- ☐ Hispanic
- ☐ Other
- ☐ Declined to specify

Responsible Party Name: _____ **Date of Birth:**____/____/____

Emergency Contact Name: _____ **Phone Number:** _____

Relationship:_____ **Address:** _____

HIPAA - Hull Dermatology, P.A. may release financial/medical information to:
Names:
_____
Phone numbers:
_____

500 S. 52nd Street | Rogers, AR 72758 | Hullderm.com | Telephone: 479-254-9662 | Fax: 479-254-9652

Patient Name: _____ DOB: _____

Payment policies:

Insurance: We participate in most insurance plans including Medicare. You are responsible for verifying participation in your specific plan network. Knowing and understanding your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding coverage. Additionally, if eligibility is not verifiable, payment will be due at the time of service.

Benefits Assignment: I hereby authorize the assignment of benefits (payments) directly to Hull Dermatology, P.A. For all my insurance claims related to services received. I agree to pay all charges that exceed or are not covered by my insurance. I understand that co-pays, deductibles, and non-covered services are due at time of service as this arrangement is part of my contract with my insurance company. Failure on our part to collect co-payments and deductibles can be considered fraud.

Please be aware that some services you receive may be non-covered. Our office will try to inform you of these services prior to treatment. Ultimately it is your responsibility to know your benefits and non-covered services will be the patient's responsibility.

Claims review: We try to finalize all charges at the time of service, but these charges are subject to review by in-house billers. Any missed charges will be billed separately.

Record release: I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Claims Submission: We Will submit your claims and assist in any way within reason to get your claims paid. Often your insurance will need you to supply information. It is your responsibility to comply with these requests. Please be aware that the balance of you claim is your responsibility whether your insurance pays.

Children of Divorced parents: Responsibility for payment for treatment of minor children, whose parents are divorced, rest with the parent who seeks treatment. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of Hull Dermatology.

Pathology/Lab Billing: When a lesion is removed in office, it is the standard of care to have a pathologist examine the specimen. These services are primarily performed in-office but are billed on a separate claim and service provider. Due to this, your insurance may assess a separate co-payment deductible. Lab and pathology that is referred out is billed by the lab company: any questions regarding those charges needs to be directed to them. These charges are not collected at time of service.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if the balance remains unpaid it will be referred to a collection agency.

Our office is committed to providing the best treatment to our patients. Our charges are representative of the usual and customary charges for our area. We thank you for understanding our payment policy.

By signing below, you acknowledge that you have read and understand the Hull Dermatology payment policies.

Signature of responsible party: _____ **Date:** _____

Cancellation and Missed Appointment Policy:

At Hull Dermatology and Aesthetics, we are dedicated to our patient care and service. We try to contact our patients at least 24 hours before their scheduled appointment to remind them of the date and time. If you are unable to keep a scheduled appointment, we request that you inform us by telephone at least 48 business hours in advance. This allows us to contact patients on our waiting list and offer the time slot to them. Our Provider's time is valuable as we always have an extensive waiting list. Patients who do not notify us at least 48 business hours before their scheduled appointment time may be assessed a fee that is specific to their type of appointment. The fee breakdown is below.

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- ☐ I understand that by not notifying the Doctor's office that I will be unable to attend my scheduled routine follow-up or excision appointment that I will be charged a $50 fee.
- ☐ I understand that by not notifying the Doctor's office that I will be unable to attend my scheduled Mohs surgery that I will be charged a $100 fee.

Late arrivals: To ensure the quality of your treatment, arriving late you a scheduled appointment may result in your treatment being shortened, the technician being changed, or your appointment being rescheduled for a later date.

Price Changes: Though we will make every effort to keep you informed of price changes our fees and services are evaluated continuously and are subject to change. Please note that if you find a better price advertised locally, we will be happy to match that price when presented the advertisement.

Products and Services: All sales are final. Only defective products can be returned. Please read all consent closely for side effects; every patient is different and can respond differently to treatment. No refunds are given on services.

By signing below, you acknowledge that you have read and understand the Hull Dermatology policies.

Signature of Responsible Party: _____ **Date:** _____

Notice of privacy practices:

Revised September 8, 2011. This information is made available to all patients. This notice describes how medical information about you may be used and disclosed and how you may have access to this information. Please review it carefully.

This notice applies to all the records of your care generated by the practice, whether made by the practice or an associated facility.

- Any health care professional authorized to enter information into your chart (including physicians, Pas, RNs, etc.)
- All employees, staff and other personnel that work for or without practice
- Our business associates (including a billing service or facilities to which we refer patients), on-call physicians and so on. Hull Dermatology provides this notice to comply with the privacy regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION: We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you. We need this record to provide your care and to comply with certain legal requirements.

By listing your Primary Care Physician (PCP), we can share and obtain information critical to your care. Please update us regularly if this information changes, so we may keep your PCP informed of your care.

Signature of Responsible Party: _____ **Date:** _____

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Patient Name: _____ DOB: _____

Insurance Information:

Primary Insurance: _____ Member ID Number: _____
Policy Holder Name: _____ Date of Birth: _____
Social Security Number: _____ Employer: _____

Secondary Insurance: _____ Member ID Number: _____
Policy Holder Name: _____ Date of Birth: _____
Social Security Number: _____ Employer: _____

Medical History Questionnaire

Are you pregnant? Yes___ No___
Are you allergic to any medications? Yes_____ No_____ **If you do, list meds and reactions below:**

_____

Have you ever had a reaction to Novocaine, Lidocaine, bandages, or topical antibiotics (Neosporin)? Yes___ No___ **If yes, please list:**

_____

Please list current medication you are taking (Including prescriptions, over the counter meds, vitamins, herbal supplements):

_____
_____
_____

Please list any allergies that you have:

_____
_____
_____

Have you had surgery or have been hospitalized in the past year? If yes, please list:

_____
_____
_____

Have you had skin cancer surgery in the past? Yes___ No___
Please list any chronic medical conditions for which you are currently being treated:

_____
_____
_____

Has anyone in your family had a history of the following? If yes, please list who (Mother, Father, Sister(s), Brother(s), Daughter(s), Son(s), other):

- ☐ Melanoma _____
- ☐ Atypical moles _____
- ☐ SCC _____
- ☐ BCC _____
- ☐ Actinic Keratosis _____
- ☐ Unknown _____

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Patient Name: _____ DOB: _____

Please check all that apply to you (Currently have or have had in the past)

General Dermatology:

- ☐ Melanoma
- ☐ Atypical moles
- ☐ Dysplastic moles
- ☐ Squamous Cell Carcinoma
- ☐ Basal Cell Carcinoma
- ☐ Actinic Keratosis
- ☐ Skin cancer (Type unknown)
- ☐ Chronic Skin disease
- ☐ History of keloid/scarring
- ☐ Bleeding easily
- ☐ HIV

Social History:

- ☐ Had more than one severe sunburn
- ☐ Had significant occupational sun exposure
- ☐ Use or have used a tanning bed
- ☐ Use sunscreen
- ☐ Been exposed to HEP A, B, C, D
- ☐ Been Exposed to HIV
- ☐ Use or have used alcohol
- ☐ Use or have used tobacco
- ☐ Used Drugs (including marijuana)
- ☐ Traveled outside the US in the last three months

Have you ever had a history of? Please check all that apply:

- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic cough
- ☐ Morning cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Heart attack
- ☐ Irregular heartbeat
- ☐ Phlebitis
- ☐ Inflammation of vein
- ☐ Blood clots
- ☐ Pacemaker
- ☐ fainting
- ☐ Diabetes
- ☐ Excessive thirst/hunger
- ☐ Amputation
- ☐ Thyroid disease
- ☐ Kidney disease/failure
- ☐ Dialysis
- ☐ Urinary tract infection
- ☐ Stomach absorptive disorder
- ☐ Nausea, vomiting, diarrhea when taking antibiotics
- ☐ Yeast infection when taking antibiotics
- ☐ Arthritis/ joint deformity
- ☐ Arthralgia
- ☐ Limited motion
- ☐ Artificial joint
- ☐ Convulsions, Epilepsy, Seizures

Allergy

- ☐ Runny nose
- ☐ Scratchy nose
- ☐ Itchy eyes
- ☐ Sneezing
- ☐ Ear fullness
- ☐ Stuffy nose
- ☐ Cough

Constitutional

- ☐ Weight change
- ☐ Loss of appetite
- ☐ Fever
- ☐ Weakness
- ☐ Night sweats
- ☐ Breast feeding (if applicable)

Dermatology

- ☐ Suspicious lesions
- ☐ Suspicious moles
- ☐ Rash
- ☐ Itching
- ☐ Dry or sensitive skin
- ☐ Photosensitivity
- ☐ Hives
- ☐ Hair loss
- ☐ Lumps
- ☐ Jaundice

ENT

- ☐ Nose bleeds
- ☐ Change in voice
- ☐ Sore throat
- ☐ Difficult swallowing

Neurology

- ☐ Headache
- ☐ Tingling numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Focal weakness

Cardiology

- ☐ Palpitations
- ☐ Chest pains
- ☐ High blood pressure

Hematology

- ☐ Easy bruising
- ☐ Swollen glands
- ☐ Fatigue

Psychology

- ☐ Depression

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Gastroenterology
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Constipation
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Change in bowel habit

Respiratory
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Cough
- ☐ Wheezing
- ☐ congestion

- ☐ High stress
- ☐ Mood swings
- ☐ Suicidal ideation
- ☐ Obsessive-compulsive tendencies

Genitourinary Female
- ☐ Premenstrual syndrome
- ☐ Infertility
- ☐ Dysmenorrheal
- ☐ Frequent yeast infections
- ☐ Vaginal itching
- ☐ Intermenstrual bleeding
- ☐ Pelvic pain
- ☐ Sexual activity
- ☐ Irregular periods
- ☐ Abnormal vaginal discharge

Ophthalmology
- ☐ Eye irritation
- ☐ Drainage from eyes
- ☐ Blurring of vision

Endocrinology
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive urination
- ☐ Cold intolerance
- ☐ Heat intolerance

Urology
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Urinary incontinence

Musculoskeletal
- ☐ Joint stiffness
- ☐ Leg cramps
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle aches

Interpreter Services

Hull Dermatology, PA has arranged for language assistance services free of charge. Call 479.254.9662 TTY 479.254.9662