BRENTWOOD DERMATOLOGY

MR# _____ **BASIC INFORMATION** Today's date:_____

Name _____ Preferred Name _____

Home Address_____ City/State _____ ZIP Code _____

Best Daytime Phone Number ( ) _____ Cell Phone Number ( )_____

Birth Date ___/___/___ SSN_____ E-Mail_____

Patient Employer Name _____ Phone ( ) _____

Pharmacy Name & Address _____ City_____

Who is your Primary Care Physician? _____City & State_____

Local Emergency Contact: _____ Phone: ( )_____
Relationship:_____

**Who may we speak to regarding your medical condition?**

Contact: _____Phone: _____ Relationship: _____
Contact: _____ Phone: _____ Relationship:_____

**How may we contact/ leave a message for your upcoming appointment reminders:**
Phone: yes____ no____ Text: yes____ no____ Email: yes____ no ____

## INSURANCE INFORMATION

☐ Yes – I have insurance coverage. Please file to the insurance plan listed below.
☐ No – I have NO insurance coverage and have made payment arrangements.

*Primary Insurance Company Name: _____ Network _____

Employer _____ Policy Holder Name _____ DOB _____/_____/_____
Relationship to policy holder (circle one) Self Spouse Child Other

*Secondary Insurance Company Name: _____ Network _____

Employer _____ Policy Holder Name _____ DOB _____/_____/_____
Relationship to policy holder (circle one) Self Spouse Child Other

## RELEASE AUTHORIZATION

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize payment of insurance benefits directly to Brentwood Dermatology.

**HIPAA INFORMATION: Your medical information disclosed will be used and forwarded in order to provide continuing treatment or care, filing your claims, and all other healthcare operations only.**

Patient/Guardian Signature _____ Date _____

Print Name _____ Date of Birth _____

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# GENERAL POLICIES

**Appointment and Arrival Times**

Scheduling appointments for our Brentwood office can be done by calling (615) 377-3448, Monday-Friday 8:00 am -4:30 pm. We ask that you arrive 15 minutes prior to your appointment to allow time for administrative tasks (i.e.: update of patient information, collecting of copayments, deductibles, and coinsurance, etc.). ***All co-pays, coinsurance and/or deductibles are due at the time of service. The amount collected at your appointment is based on the available insurance fee schedule and is an ESTIMATION of your patient responsibility. There may be additional patient responsibility due once your insurance processes your claim, or you may be due a refund. Refunds and Patient Statements are processed on a monthly basis. A $35.00 Returned Check Fee will be applied to your account if your check is returned for insufficient funds.***
Please bring your photo ID and insurance card(s) and a list of your current medications including the name of the medication, and the dosage and frequency (please include prescription medicines, over-the-counter and vitamins $ supplements).

In order to serve our patients more efficiently, we have instituted a cancellation policy. Time has been specifically reserved for your provider appointment, procedure or treatment. If you cannot make it to your scheduled appointment, **please contact us 24 hours in advance to cancel or reschedule your appointment**. As a courtesy, we do make reminder calls for appointments 24-36 hours prior to your scheduled appointment. If you do not receive your message or we have incorrect information the cancellation policy will still be in effect.

If you choose not to provide appropriate notice or miss your appointment you will be subject to the following charges:

$50.00 Consultation, New Patient, or Return appointment
$100.00 MOHS or Excision surgery appointment

***We find it necessary to implement this policy due to the high demand for patient appointments. With appropriate notice, we are able to schedule other patients in your appointment time slot and accommodate these needs.***

**Late arrivals**
Our office strives hard to see our patients in a timely manner. Therefore, if you arrive 10 or more minutes late, we may have to re-schedule your appointment

**Pathology & Lab services**
Please not that if you have biopsies, excision, blood work, etc., there will be a separate bill from these individual providers. For pathology services, we utilize St. Thomas Pathology Associates, all lab services are forwarded to PathGroup.

**Minors**
Minors must be accompanied by their legal guardian during their first visit. After the first visit, a parental waiver must be signed if their guardian will not be present during future appointments.

_____ _____
Signature of patient Date

_____ _____
Patient's printed name Patient's Date of Birth

William McDaniel, MD • John Starling III, MD
Lilly Zhu, MD • Sarah Hill FNP-BC
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Patient Name:_____Date of Birth:_____

Preferred Name:_____

**Medication Allergies: please CIRCLE NKDA if none:** **NKDA**

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

**List of ALL current medications: including prescriptions, over the counter, vitamins and supplements, or eye drops:**

Name: _____ Dose/Route: _____Frequency/Directions: _____
Name: _____ Dose/Route: _____Frequency/Directions: _____
Name: _____ Dose/Route: _____Frequency/Directions: _____
Name: _____ Dose/Route: _____Frequency/Directions: _____

| Do you take these medications daily? | Yes | No |
|---|---|---|
| Aspirin _____mg | | |
| Advil/ Motrin/ Aleve/ Celebrex? Name:_____ Dose: | | |
| Coumadin/Plavix/Xarelto Pradaxa/Warfarin? | | |
| Any non-listed blood thinner? Name: _____ | | |

| Medical History: Past or Present | YES | NO | Explain: |
|---|---|---|---|
| Blood or Bleeding Disease | | | |
| Heart Disease | | | |
| History of Heart Murmur? | | | |
| Kidney Disease | | | |
| Liver Disease | | | |
| Lung Disease | | | |
| Thyroid Disease | | | |
| Arthritis | | | |
| Diabetes | | | |
| High Blood Pressure | | | |
| Infectious Disease | | | |
| Psychological Disease i.e. depression/anxiety | | | |
| Ear/Nose/Throat Disease | | | |
| Non Skin Cancer | | | |
| Immunological Disease | | | |
| Skin Disease | | | |
| Skin Cancer | | | |
| Melanoma | | | |
| Eye Disease | | | |
| Contact Allergies: Latex/Nickel/Rubber | | | |
| Do you have Pacemaker/Defibrillator/ Implant Cardiac Monitor | | | |
| Artificial joint or heart valve | | | |
| Do you form Keloids? (THICKENED SCARS) | | | |
| Do you take antibiotics prior to routine dental procedure? | | | |
| Have you ever fainted for local anesthesia? | | | |
| Have you ever had rheumatic Fever? | | | |
| **65 years and older**: Have you ever had a Pneumonia Vaccination? | | | |
| **All Ages**: Have you had a Flu shot? | | | |

| Social History | Yes | No | How Much? |
|---|---|---|---|
| Do you live alone? | | | |
| Do you drink Alcohol? If yes, how many a day? | | | 1 ___ 2___ 3 + ___ |
| Do you use recreational drugs? | | | |
| Have you used a tanning bed? | | | |
| Do you use ANY type of tobacco products? | | | |
| Have you ever Smoked? | | | |

| Family Medical History: | Mother | Father | Blood |
|---|---|---|---|
| Acne | | | |
| Arthritis | | | |
| Asthma | | | |
| Non- Skin Cancer | | | |
| Eczema | | | |
| Diabetes | | | |
| Lupus | | | |
| Hives | | | |
| Melanoma | | | |
| Skin Cancer | | | |
| Psoriasis | | | |
| Hay Fever | | | |

| ***Females only:** | Yes | No |
|---|---|---|
| **Do you take birth control?** | | |
| **Are you pregnant?** | | |
| **Are you breast feeding?** | | |
| **Do you plan on becoming pregnant?** | | |

**List Surgeries & Dates (please list ALL):**

1. _____ 3. _____ 5. _____
2._____ 4._____ 6. _____

Occupation: _____ Pharmacy Name: _____ Phone: _____

Hobbies: _____ Address/City: _____

Leisure Activities: _____ OTHER Medical Conditions: _____