LAKEWAY DERMATOLOGY ASSOCIATES, PC

400 E. ECONOMY RD., SUITE 8
MORRISTOWN, TN 37814
423-587-4600
FAX 423-587-1729

112 W. BROADWAY BLVD.
JEFFERSON CITY, TN 37[illegible]
865-262-8240
FAX 865-262-8242

PATIENT INFORMATION SHEET

Today's Date _____

Patient's Name _____
First Middle Initial Last

Address _____ Home Phone _____

MAY WE SEND YOU TEXT MESSAGES FOR APPOINTMENT REMINDERS? _____YES _____NO

City, State, Zip _____ Mobile Phone _____

Social Security Number _____ E-Mail Address _____

Birth Date _____ Age _____ Gender: Male _____ Female_____

Single ___ Married ____ Widow ___ Divorced ____ Race: Caucasian ____ Black ____ Other____

Employer _____ Business Address _____

Occupation _____ Business Phone _____

Spouse's Name _____ Birth Date _____ Social Security # _____

Employer _____ Business Address _____

Spouse's Occupation _____ Business Phone _____

Name of Primary Care Doctor _____ Phone _____

Preferred Pharmacy Name _____ Phone Number _____

Out of State address if applicable

Address _____

City, State, Zip _____

LANGUAGE: _____
ETHNICITY:
Hispanic or Latino _____
Other

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, _____ (print name), _____ (date of birth) give permission for Lakeway Dermatology Associates, P.C. and any of the practice's staff, medical providers, and business associates to release my medical information to other physicians/hospitals which may request this information for the purpose of diagnosing and/or treating a medical condition. These records may be mailed, faxed, or sent electronically. I also give my permission for Lakeway Dermatology Associates, P.C. to obtain my medical records from other physicians/hospitals for the purpose of diagnosing and/or treating my medical condition(s). I also give permission to release medical information regarding my care to my insurance company(s), or any outside source paying on my account in order for them to process/pay my claims.

I also permit the staff of this practice to telephone my home for the purpose of giving results of medical tests, changing appointments, appointment reminders and billing inquires. I give permission for the staff of this practice to leave messages on my answering machine/service stating that I need to call the office regarding test results or appointments. In certain instances test results may be left as a message; discretion to be determined by the practice. Test results, billing inquiries, and the discussion of appointments and/or their purpose(s) may be given to/discussed with the individuals listed below. Unless otherwise noted, the persons listed below will stand as my emergency contacts.

Name/relationship _____/_____/_____
Home Mobile

Name/relationship _____/_____/_____
Home Mobile

Name/relationship _____/_____/_____
Home Mobile

Name/relationship _____/_____/_____
Home Mobile

I am aware that I may revoke this release at any time by informing Lakeway Dermatology Associates, P.C. at the offices located at the above listed addresses. I agree to hold harmless the practice, staff, medical providers, and business associates for any action resulting from the release of these records. I understand that Lakeway Dermatology Associates, P.C. has no control of any subsequent release of my records after they leave this practice.

Power of Attorney: If you have a power of attorney please provide a copy to this practice. We cannot honor a power of attorney without you providing a copy for our records.

HIPAA: This Practice's Notice of Privacy Practices are posted in the front of both of our facilities at the above listed addresses. You will be provided a copy upon request.

Payment Responsibility: Payment must be made at the time of visit, unless otherwise approved. I understand that I am fully responsible for the payment of my account. I attest that all the information I have given on this form is correct, to the best of my knowledge.

Patient Signature: _____

Date Signed: _____

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Family History (Brothers | Sisters | Parents | Grandparents)

(check all that apply)	✓	Afflicted Family Member	Notes
No Relevant Family History			
Unknown - Adopted			
Autoimmune Disorders			
Colon Cancer			
Diabetes			
Glaucoma			
High Blood Pressure			
High Cholesterol			
Liver Disease			
Lung Disease			
Malignant Melanoma			
Obesity			
Premature Coronary Heart Disease			
Skin Cancer			
Thyroid Disease			

Smoking Status (check one)

Current every day smoker	
Current some day smoker	
Former smoker	
Never smoked	
Smoker, current status unknown	
Unknown if ever smoked	
Heavy tobacco smoker	
Light tobacco smoker	

Alcohol Consumption (check one)

None	
Every Day	
Social	

Hobbies (check those that apply)

- ☐ Reading
- ☐ Music
- ☐ Sports
- ☐ Gardening
- ☐ Travel
- ☐ Other _____

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Name _____ Birth Date _____

PAST MEDICAL HISTORY (check "yes" to those that apply)

YES

- ❑ No Past Medical History
- ❑ Acne
- ❑ Acne Scarring
- ❑ Arthritis (degenerative)
- ❑ Arthritis (rheumatoid)
- ❑ Asthma
- ❑ Athlete's Foot
- ❑ Boils or Sores
- ❑ Breast Cancer
- ❑ Cancer
- ❑ Cholesterol Elevation
- ❑ Cirrhosis of the Liver
- ❑ Diabetes
- ❑ Eczema
- ❑ Fever Blisters
- ❑ Fibromyalgia
- ❑ Free Bleeder
- ❑ Hay Fever
- ❑ Headache (Migraine)
- ❑ Headache (Tension)
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives
- ❑ Irritable Bowel
- ❑ Jock Itch

YES

- ❑ Leg Ulcer
- ❑ Lupus
- ❑ Malignant Melanoma
- ❑ Mouth Ulcers
- ❑ Nail Fungus or thickening
- ❑ Neuropathy
- ❑ Patient always burns, sometimes tans
- ❑ Patient is light black African American
- ❑ Patient never burns
- ❑ Patient never tans, always burns
- ❑ Patient skin is black
- ❑ Patient tans easily, rarely burns
- ❑ Prostate enlargement
- ❑ Psoriasis
- ❑ Racing Heart Rate
- ❑ Radiation
- ❑ Skin Cancer
- ❑ Skin Disease
- ❑ Stroke
- ❑ Sun Poisoning
- ❑ Thyroid Disorder
- ❑ Tuberculosis
- ❑ Ulcers

- ❑ Other _____
- ❑ Other _____

PAST SURGICAL HISTORY (check "yes" to those that apply)

YES

- ❑ No Past Surgical History
- ❑ Abdominal Surgery
- ❑ Appendectomy
- ❑ C-Section
- ❑ Gallbladder
- ❑ Hernia Repair
- ❑ Hysterectomy
- ❑ Lymph Nodes Resection

YES

- ❑ Mastectomy (lumpectomy)
- ❑ Mastectomy (radical)
- ❑ Open Heart Surgery
- ❑ Orthopedic Surgery
- ❑ Skin Cancer
- ❑ Thyroidectomy
- ❑ Tonsillectomy
- ❑ Other _____

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DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Circle all the currently apply.

Blisters	Nasal Congestion
Bruising	Mouth sores
Growths	Sore throat
Hair problems	Sinus problems
Itching	Cold hands or feet
Nail problems	Cold or heat intolerance
Rash/Skin problems	Heartburn
Sun sensitivity	Bloody stool
Pregnant	Menstrual irregularity
Unexpected weight loss or weight gain	Frequent urination
Redness of the eye	Swollen or painful joints
Dry eyes	Anxiety/Depression
Poor vision	Numbness or tingling
Earache	Cough
Hearing loss	Free bleeder
Nose bleed	Anemia

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Medical History Authority

I hereby give Lakeway Dermatology Associates, P.C. authority to download my prescription history from Surescripts/RXHUB. I understand the prescription history will solely be used for medical purposes.

Video/Audio Policy

It is the recommendation of the Tennessee Medical Association and policy of Lakeway Dermatology Associates, P.C. that there will be NO video/audio recordings of office visits or medical/surgical procedures. By signing below, I have read and understand the above policies.

Name _____ Birth Date _____

Signature _____ Date _____

Patient/Legal Guardian

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Financial Policy

Patient Name: _____ Date of Birth: ____/____/_____

Dear Patient:

We would like to share the following polices with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

a) The annual deductibles
b) Copayments
c) Charges for non-covered or cosmetic services*

* You will be asked to sign an Advanced Notice of Liability Form (ABN) in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare, as well as a secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 90 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Non-Medicare/Commercial Plans:

If we participate (are contracted) with a commercial or Medicaid plan under which you are covered, we will bill the carrier for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

a) The annual deductibles
b) Copayments
c) Charges for non-covered or cosmetic services

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balanced billed after we obtain a denial from your insurance carrier.

If you have a commercial or Medicaid plan that we are not contracted with, full payment is required for all services rendered on day services are rendered. We will not bill any insurance carrier that we are not contracted with.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ ____/____/_____

Patient signature **Date**