Premier Dermatology
And Skin Cancer Center P.L.L.C

Michele Hughes MD, F.A.A.D.

PATIENT INFORMATION

Email address: _____

Patient Name: _____

Patient DOB: _____ SSN: _____

Gender: Male _____ Female: _____ Marital Status: _____

Patient Address: _____
Street

_____
City State Zip Code

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

Preferred Language: _____ Race & Ethnic Group: _____

****If Patient is under 18 years of age; Legal Guardian or Responsible Party MUST be present with valid ID****

Responsible Party's Name: _____

Address: _____
Street

_____
City State Zip Code

PREFERRED METHOD OF CONTACT: Phone___ Email____Text_____Other_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____

TV____ Newspaper/Magazine____ Billboard___ Website _____ Former Pt._____ Other___

5935 Washington Ave. Ste. A Ocean Springs, MS 39564
Phone and Fax (228) 215-0669 www.premierdermclinic.com

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Person Who Holds Insurance Policy: _____

Policy Holder's
DOB: _____ SSN# _____

Policy Holder's Address: _____

Policy Holder's Employer Name: _____

Patient's Relationship to Policy Holder: _____

Insurance Company's Name: _____

Group Number: _____

Insured Member ID: _____

SECONDARY INSURANCE

Name of Person Who Holds Insurance Policy: _____

Policy Holder's
DOB: _____ SSN# _____

Policy Holder's Employer Name: _____

Patient's Relationship to Policy Holder: _____

Insurance Company's Name: _____

Group Number: _____

Insured Member ID: _____

EMPLOYER INFORMATION

Company Name: _____

Address: _____

Phone Number: _____

PATIENT PRIVACY POLICY ACKNOWLEDGEMENT

I have read and understand the Privacy Policy for Premier Dermatology and Skin Cancer Center. I understand that I will be given a copy of the policy if requested. Below is a list of people that I give permission to discuss my medical care:

Name	Contact Number	Relationship
1.		
2.		
3.		
4.		
5.		

I authorize Premiere Dermatology and Skin Cancer Center to release me medical records to the following physicians:

Physician Name	Clinic Name
1.	
2.	
3.	
4.	
5.	

Patient Signature_____ Witness_____

Emergency Contact

Name: _____ Phone Number: _____

Phone Number at which it is ok to contact me: _____, You may leave a message regarding my care: Yes _____ No _____

Premier Dermatology and Skin Cancer Center, PLLC

5935 Washington Ave, Suite A

Ocean Springs, MS 39564

(228) 215-0669 Michele Hughes, MD

Financial Policy

Premier Dermatology and Skin Cancer Center is currently accepting most medical insurances. It is suggested, however, that you contact your insurance company for specific benefit questions. Most insurance companies require the patient to pay either an office visit co-pay or a portion of their deductible.

"Co-Pays" are considered for an office visit only and generally does not include procedures. Such procedures that may require a coinsurance payment include, but not limited to, Cryosurgery ("freezing"), biopsies, and surgical removal of growths. These procedures are typically applied to the insurance deductible, therefore would be paid based on a percentage. This amount will be determined at the time of the service and payment will be expected at the time of check-out.

The staff at Premier Dermatology is dedicated to providing superior service to their patients. We are committed to working with your insurance company to ensure timely billing practices on your behalf. Your cooperation in keeping the office up to date on any changes in your insurance, is greatly appreciated. If after 60 days of billing and working with your insurance company, payment has not been made, the balance will then become the responsibility of the patient. Premier Dermatology and Skin Cancer Center, PLLC will then provide the patient with all necessary information to file the insurance.

Patients of Premier Dermatology and Skin Cancer Center, PLLC will be responsible for all "Co-Pay's", coinsurance, and any outstanding balances at the time of check–in. For your convenience, we will accept cash, check, Mastercard, Visa, and Discover. We also offer Care Credit for those patients in need of financial assistance. This option may be used for any medical procedure or elective cosmetic procedure that you may desire. This option will allow our patients to create a payment plan that works best for his/her budget. Care Credit has a variety of payment plan options depending on your needs .If you are interested in applying for Care Credit, you can pick up an informative brochure in our waiting room, go online to www.carecredit.com, or call us for information on how it works.

Patients that are being seen for any type of elective procedure such as, cosmetic fillers, laser treatments, or aesthetics, will be required to have a credit card on file. This credit card will only be charged when the patient is in the office. All patients having any type of cosmetic procedure, the credit card will be used at the time of check in for an estimated portion of the procedure, and the remainder will be charged at the time of check out. If there is a credit owed to the patient, it will be given at the time of check out.

Acknowledgement of Financial Policy

I have read and understand the financial policy for Premier Dermatology and Skin Cancer Center. I further authorize the use of my credit card that is on file, to be used for all elective procedures that are performed at Premier Dermatology and Skin Cancer Center.

_____

Patient Printed Name Date

_____

Patient Signature

_____

Premier Dermatology Staff Witness Date

Premier Dermatology and Skin Cancer Center, PLLC

5935 Washington Ave, Suite A

Ocean Springs, MS 39564

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Cancellation Policy

Premier Dermatology and Skin Cancer Center requires a 24 hour notice on all appointment cancellations. If a patient cancels his/her appointment less than 24 hours prior to his/her scheduled appointment time, there will be a $50.00 cancellation fee. This fee is not payable by insurance and therefore, will be the patient's responsibility. This fee must be paid prior to, or at the patient's next appointment.

Please be considerate of other patient's waiting to be seen, and cancel if needed, in a timely manner. We understand that circumstances arise, and we will work with you on a case by case basis. However, if this becomes a recurring issue, we will not be able to continue to reconsider the fee.

Thank you for your understanding.

Patient Printed Name Date

Patient Signature

Premier Dermatology and Skin Cancer Center Staff Date

History and Intake Form

Past Medical History: (circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other

_____

_____

Past Surgical History: (circle all that apply)

Appendix Removed
Bladder Removed
Breast Surgery _____
Colectomy
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee
Joint Replacement, Hip
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other

_____

_____

Skin Disease History: (circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/ Allergies
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other

_____

_____

Do you wear sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma?

Yes No

If yes, which relative(s)?

_____

_____

Any other family history:

_____

_____

_____

Preferred Pharmacy:

_____

_____

Medications: (Please enter all current medications)

_____

_____

_____

_____

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_____

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Allergies: (Please list all allergies)

_____

_____

_____

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_____

_____

_____

_____

Social History: (circle all that apply)

Cigarette Smoking:

Never Smoked
Quit: Former Smoker
Smoke less than daily
Smoke daily

Alcohol Use: Alcohol: none
Alcohol: less than 1 drink a day
Alcohol: 1-2 drinks a day
Alcohol: 3 or more drinks a day

Review of Systems: Are you currently experiencing any of the following? (circle all that apply)

Symptom

Problems with bleeding
Problems with Healing
Problems with Scarring (Keloids)
Rash
Immunosuppression
Hay Fever
Fevers or Chills (currently)
Night sweats
Unintentional Weight Loss
Thyroid Problems
Sore Throat
Blurry Vision
Abdominal Pain
Bloody Stool
Bloody Urine
Joint Aches
Muscle Weakness
Neck Stiffness
Headaches
Seizures
Cough
Shortness of Breath
Wheezing
Anxiety
Depression

Other Symptoms:

_____

_____

Alerts: Are your currently experiencing any of the following? (circle all that apply)

Alert

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotic Ointment
Artificial Heart Valves
Artificial Joints within the last 2 years
Blood Thinners
Pacemaker
Defibrillator
History of Skin Infections- MRSA
Premedication needs prior to procedures
Rapid heartbeat with epinephrine
Pregnancy or planning pregnancy
Breast Feeding

Other Symptoms:

_____

_____

You may take pictures of my skin to place in my chart: Yes _____ No _____