Premier Dermatology and Skin Cancer Center

5935 Washington Ave

Ocean Springs, MS 39564

(228) 215-0669

Michele Hughes, M.D. Ashley Bourgeois, PA-C Lindsey Zubritsky, M.D

Patient Information:

Patient Name (Mr./Mrs/ Dr.) _____

Mailing Address_____

City_____ State_____ Zip_____

Contact information Main Phone_____ Cell Phone _____

Date of Birth _____/_____/_____ SSN: _____-_____-_____

Gender Male_____ Female_____ Race & Ethnicity _____ Marital Status_____

Preferred Language _____ Email Address _____

Employer _____ Occupation _____

Financial Information:

Responsible Party Name _____

Mailing Address_____

City_____ State_____ Zip _____

Relationship to patient_____ SSN _____-_____-_____ DOB _____/_____/_____

Employer_____ Occupation _____

Work Phone _____ Main Phone _____Cell Phone_____

Credit Card to be on file (optional)_____

Expiration Date _____ CVV _____

Primary Insurance

Name of Policy Holder _____

Relationship to Patient _____

DOB_____ SSN_____-_____-_____

Insurance Co._____

Member ID#_____

Secondary Insurance

Name of Policy Holder_____

Relationship to Patient _____

DOB_____ SSN_____-_____-_____

Insurance Co._____

Member ID#_____

Patient Name

_____DOB_____/_____/_____

Women's Health (Please circle all that apply)

Urinary Incontinence Loss of Vaginal Tone

Vaginal Dryness Pain during Intercourse

Skin Disease History (Please circle all that apply)

Acne Flaking or Itchy Scalp

Actinic Keratosis Melanoma

Basal Cell Skin Cancer Precancerous Moles

Blistering Sun Burns Psoriasis

Dry Skin Squamous Cell Skin Cancer

Eczema

Other_____

_____

Do you wear sunscreen? Yes or No

Do you tan in a tanning salon? Yes or No

Do you have a family history of Melanoma? Yes or No

If yes, which relative(s)?_____

Medications (Please list all current medications)

_____

_____

_____

Family History (1st Degree Relative)

_____

_____

Preferred Pharmacy_____

Social History (Circle all that apply)

Cigarette Smoking: Never Smoked Smoke Daily Former Smoker

Alcohol Use: Never Drink Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day

Alerts:

Allergy to Adhesive Artificial Heart Valve MRSA Breastfeeding

Allergy to Lidocaine Blood Thinners Pacemaker

Allergy to Topical Antibiotic Ointments Defibrillator Pregnant or planning

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HISTORY AND INTAKE FORM

Patient Name_____ **DOB** _____/_____/_____

Past Medical History (Please circle all that apply)

Anxiety	Colon Cancer	Hearing Loss	Lung Cancer
Arthritis	COPD	Hepatitis	Lymphoma
Asthma	Coronary Artery Disease	High Blood Pressure	Prostate Cancer
Atrial Fibrillation	Depression	HIV/AIDS	Radiation Treatment
Bone Marrow	Diabetes	High Cholesterol	Seizures
Transplantation	End Stage Renal Disease	Thyroid Disease	Stroke
Breast Cancer	GERD	Leukemia	

Other:_____

_____

Past Surgical History (Please circle all that apply)

Mechanical Valve Replacement If so, what year_____ Joint Replacement - which joint _____ Year_____

Other:_____

Review of Systems (Please circle all that apply)

Problems with bleeding	Unintentional Weight Loss	Muscle Weakness
Problems with healing	Thyroid Problems	Neck Stiffness
Problems with scarring (Keloids)	Sore Throat	Headaches
Rash	Blurry Vision	Seizures
Immunosuppression	Abdominal Pain	Depression
Hay Fever	Bloody Stool	Shortness of Breath
Fevers or Chills (Currently)	Bloody Urine	Wheezing
Night Sweats	Join Aches	Anxiety

List all Allergies:

_____

_____

Patient Name

_____DOB_____/_____/_____

Women's Health (Please circle all that apply)

Urinary Incontinence	Loss of Vaginal Tone
Vaginal Dryness	Pain during Intercourse

Skin Disease History (Please circle all that apply)

Acne	Flaking or Itchy Scalp
Actinic Keratosis	Melanoma
Basal Cell Skin Cancer	Precancerous Moles
Blistering Sun Burns	Psoriasis
Dry Skin	Squamous Cell Skin Cancer
Eczema	

Other_____

_____

Do you wear sunscreen? Yes or No

Do you tan in a tanning salon? Yes or No

Do you have a family history of Melanoma? Yes or No

If yes, which relative(s)?_____

Medications (Please list all current medications)

_____

_____

_____

Family History (1st Degree Relative)

_____

_____

Preferred Pharmacy_____

Social History (Circle all that apply)

Cigarette Smoking: Never Smoked Smoke Daily Former Smoker

Alcohol Use: Never Drink Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day

Alerts:

Allergy to Adhesive	Artificial Heart Valve	MRSA	Breastfeeding
Allergy to Lidocaine	Blood Thinners	Pacemaker	
Allergy to Topical Antibiotic Ointments	Defibrillator	Pregnant or planning	

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Patient Name: _____ DOB_____/_____/_____

No Show Policy:

Premier Dermatology and Skin Cancer Center requires a 24-hour cancellation notice for all scheduled appointments. If an appointment is not cancelled within 24 hours prior to your appointment, you will be charged a $50 "No Show" fee. This fee will be due at your next appointment.

Charges from Outside Facilities:

If you have a biopsy, lab work drawn at Premier Dermatology, or a culture swab, there may be additional charges to you/ and or your insurance company by the outside facility that is running these tests.

Authorization and Release of Information: (Sign Below)

I authorize Premier Dermatology and Skin Cancer Center, to release any test results, office visit notes, diagnosis rendered to me or my minor child to any other health care provider or third party insurance company on my behalf.

Medicare Patients: (Sign Below)

I authorize Medicare to pay all benefits for rendered services to Premier Dermatology and Skin Cancer Center on my behalf.

Signature of Patient (or Parent of Minor)_____

Printed Name of Patient_____

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Patient Notice of Privacy Policy Acknowledgement

Patient Name _____ DOB_____/_____/_____

I acknowledge that I have been given an opportunity to review Premier Dermatology and Skin Cancer Center, Notice of Privacy Practices. I further acknowledge that I have been given the opportunity to receive a copy of this Privacy Policy.

Below are ways that I have given permission for Premier Dermatology and Skin Cancer Center, to contact myself or others regarding appointment reminders, test results, questions regarding my pharmacy or medications and any other information needed for my treatment.

Contact Numbers:

Home_____ Work_____ Cell _____

Premier Dermatology and Skin Cancer Center may leave a message at Home #_____ Work#____ Cell#_____

Preferred Method of Contact: Cell _____ Home _____ Work _____

Emergency Contact:

1. Name _____ Contact Number _____
2. Name _____ Contact Number _____

Premier Dermatology and Skin Cancer Center may speak to or leave a message regarding my care with the following persons:

1. Name _____ Contact Number _____
2. Name _____ Contact Number _____
3. Name _____Contact Number _____

Signature of Patient (Legal Guardian) _____

Printed Name of Patient (Legal Guardian) _____ Date _____/_____/_____

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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 do not include procedures. Such procedures that may require a coinsurance payment include, but are 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. All coinsurance, and portions of deductibles will be determined at the time of service and payment will be expected at the time of check-out.

Patients of Premier Dermatology will be responsible for all "Co-Pays" and any outstanding balances at the time of check-in. For your convenience, we will accept cash, check, Mastercard, Visa, and Discover. There will be a 3.95% convenience fee on all credit card transactions. We also offer Care Credit for those patients in need of financial assistance. If you wish to apply, go online to www.carecredit.com. If you choose to use Care Credit for our services, there is a minimum of $200 that must be spent.

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 to 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 patients.

Patients may have the option of setting up payment arrangements for large balances at the discretion of Premier Dermatology. However, if the patient fails to follow through with the payment arrangements or fails to pay an outstanding balance, Premier Dermatology will then proceed with the collections process in Justice Court. All fees incurred during the legal process will then be added to the patient's balance.

Patients that are being seen for any elective procedure or service such as cosmetic fillers, laser treatments, or aesthetic services, will be required to pay for those services prior to being seen.

Acknowledgement of Financial Policy

I have read and understand the Financial Policy for Premier Dermatology and Skin Cancer Center. There are several payment options available to patients at Premier Dermatology. Patients may pay with cash, check, credit card or Care Credit. If I choose to use a credit card, I authorize the use of my credit card with a 3.95% convenience fee for all medical and elective procedures that are performed at Premier Dermatology and Skin Cancer Center.

Credit Card to be kept on file (optional) _____ Exp _____ CVV_____

Patient Printed Name_____ Date_____

Patient Signature _____