3025 Governors Place Boulevard
Dayton, Ohio 45409
Phone (937) 293-5567
Fax (937) 293-5568
www.daytonskincarespecialists.com

***Welcome to our practice*!**

We hope you will find the following information helpful. We respect your time and would like to make your visit to our office as efficient as possible. Every patient is very important to us.

Medical Information/HIPAA Information: We appreciate your completion of the enclosed forms. **Please complete all pages of this packet and include your name *on every page* as directed. Surgery patients, please *RETURN FORMS TO US BY MAIL* prior to your appointment, unless otherwise advised. General Dermatology patients, please bring completed forms to your appointment.** Photo identification and all insurance cards will be required at check-in on the day of your appointment.

On Time Arrival: Please arrive 15 minutes before your scheduled appointment time. Late arrival will result in an extended wait time and may require your appointment to be rescheduled.

Financial Policy & Medical Insurance: We collect co-pay, deductible and co-insurance at the time services are rendered. Insurance may not cover the full cost of your physician services; final patient responsibility for payment will be based on information received from your insurance company after the claim has been processed. Self-pay patients will be responsible for payment in full on the day of service. If you have any questions or concerns, please contact our Billing Dept. at 937-293-5567, option #4.

Cancellation: We schedule appointments several weeks out and would like the opportunity to accommodate patients on our wait list. Please notify us as early as possible if you are unable to keep this appointment at 937-293-5567, option #2.

If you have any questions regarding the above, or if we can be of further help, please do not hesitate to call our office at 937-293-5567 or visit our website at www.daytonskincarespecialists.com. For driving directions, please refer to the enclosed map.

We look forward to meeting you.

Sincerely,
Dayton Skin Care Specialists

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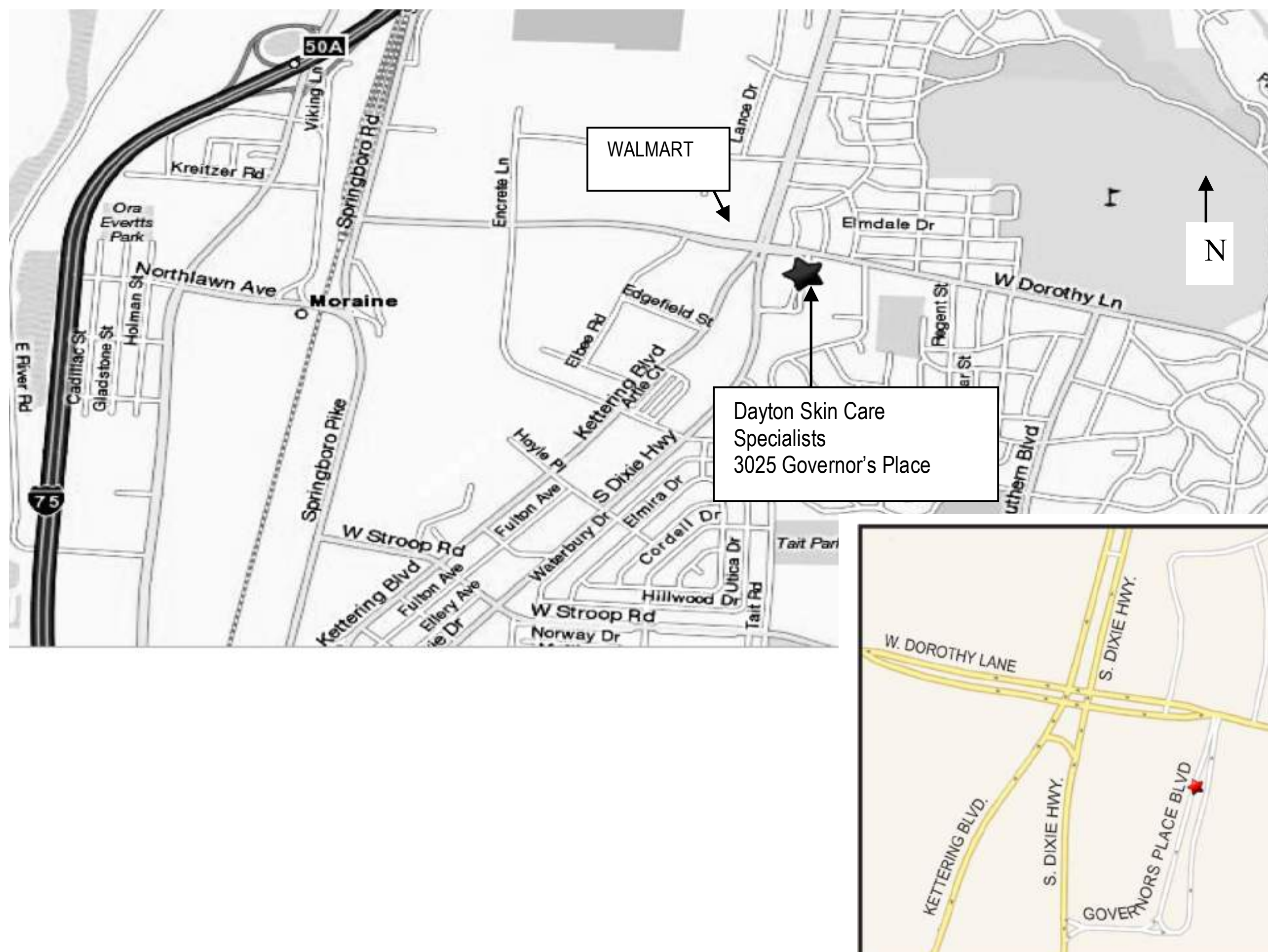

FROM NORTH DRIVING SOUTH ON I-75S:
Take the OH-741 S/SPRINGBORO RD exit, EXIT 50B. Turn LEFT onto SPRINGBORO RD/OH-741. Turn LEFT onto W DOROTHY LN. Turn RIGHT onto GOVERNORS PLACE BLVD., 3025 GOVERNORS PLACE BLVD is on the RIGHT.

FROM SOUTH DRIVING NORTH ON I- 75N:
Take EXIT 47 toward MORAINE/KETTERING. Turn RIGHT onto S DIXIE HWY. Turn RIGHT onto W DOROTHY LN. Turn RIGHT onto GOVERNORS PLACE BLVD., 3025 GOVERNORS PLACE BLVD is on the RIGHT.

FROM NORTH DRIVING SOUTH ON I-675S:
Take INDIAN RIPPLE/DOROTHY LANE exit, EXIT 10. Turn RIGHT onto E DOROTHY LANE and travel 5.6 miles to GOVERNORS PLACE BLVD. Turn LEFT onto GOVERNORS PLACE BLVD., 3025 GOVERNORS PLACE BLVD is on the RIGHT.

FROM SOUTH DRIVING NORTH I-675N:
Take INDIAN RIPPLE/DOROTHY LANE exit, EXIT 10. Turn LEFT onto E DOROTHY LANE and travel 6.5 miles to GOVERNORS PLACE BLVD. Turn LEFT onto GOVERNORS PLACE BLVD., 3025 GOVERNORS PLACE BLVD is on the RIGHT.

PATIENT INFORMATION

NAME: ____**DATE OF BIRTH:** ______________________
(FIRST) **(MIDDLE)** **(LAST)**

ADDRESS: ____**CITY:** ________________________________ **STATE:** ________ **ZIP:** ____________

RACE: ______________________________ **PRIMARY LANGUAGE:** ENGLISH SPANISH OTHER ___________________ **SEX:** MALE or FEMALE

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO **EMAIL:** ____

HOME PHONE: (____) ________________________ **WORK PHONE:** (___) _________________________ **CELL PHONE:** (____) _______________________

OCCUPATION:_________________________________ **PREFERRED PHARMACY/ADDRESS:** ____

REFERRED BY: ____ **PRIMARY CARE PHYSICIAN:** ____

EMERGENCY CONTACT NAME: ____ **PHONE:** (___) _______________________________

FINANCIALLY RESPONSIBLE PARTY (If different from the patient)

NAME: ____**DATE OF BIRTH:** ______________________

RELATIONSHIP TO PATIENT: ____ **EMAIL:** ____

ADDRESS: ____**CITY:** ________________________________ **STATE:** ________ **ZIP:** ____________

HOME PHONE: (____) ________________________ **WORK PHONE:** (___) _________________________ **CELL PHONE:** (____) _______________________

INSURANCE SUBSCRIBER INFORMATION (Please present insurance card at time of check-in)

PRIMARY INS. NAME: ____

NAME OF SUBSCRIBER: _______________________________________

SUBSCRIBER'S DATE OF BIRTH _________________________________

SUBSCRIBER'S ID# ____

GROUP #____

RELATIONSHIP TO SUBSCRIBER:_________________________________

SECONDARY INS. NAME:_______________________________________

NAME OF SUBSCRIBER:____

SUBSCRIBER'S DATE OF BIRTH__________________________________

SUBSCRIBER'S ID#____

GROUP #____

RELATIONSHIP TO SUBSCRIBER:_________________________________

ALL PATIENTS: ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans, to Dayton Skin Care Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorize Dayton Skin Care Specialists to release all information necessary to adjudicate all claims and secure payment for services rendered.

Signature:____ **Date:**______________

MEDICARE PATIENTS ONLY: I request that payment of authorized Medicare benefits be made on my behalf to Dayton Skin Care Specialists, for services furnished to me by Dayton Skin Care Specialists. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Dayton Skin Care Specialists accepts the charge determination of Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services.

Signature:____ **Date:**______________

DAYTON SKIN CARE SPECIALISTS POLICIES

_______ **Initial**	**INSURANCE:** I understand that my insurance coverage is an agreement between me and my insurance company. I am financial responsible for my co-pay, deductible, coinsurance, and non-covered services. If my insurance plan requires a referral from a primary care physician, I am responsible for obtaining the necessary referral. <u>It is my responsibility to know the requirements of my insurance program</u>. I may be responsible for the total payment of services rendered if a referral is not obtained. Dayton Skin Care Specialists strives to assist the patient whenever possible.
_______ **Initial**	**FINANCIAL RESPONSIBILITY:** I understand that I am responsible for all co-pay, deductible, coinsurance, and outstanding balances at the time of service. Co-payments and outstanding balances will be collected at check-in. I understand that my appointment may be rescheduled if I cannot meet these obligations. There will a fee of $30.00 charged to my account by Dayton Skin Care Specialists for each returned check.
_______ **Initial**	**COSMETIC AND AESTHETIC SERVICES:** <u>Payment is required in full at the time of your procedure</u>. I understand cancelation of less than 24 hours for cosmetic appointments or less than 5 days for Sculptra appointments will result in forfeit of my deposit.
_______ **Initial**	**LAB FEES:** Biopsies may be sent to an outside lab to be analyzed. The fee for this is a separate charge from the office visit and will be billed directly by the processing lab. I understand that it is my responsibility to inform the Dayton Skin Care Specialists staff or providers if my insurance policy requires use of a contracted lab or facility.
_______ **Initial**	**COLLECTION AGENCY COSTS:** In the event my account is referred to a collection agency or attorney for collection, I agree to pay all collection fees, attorney fees, court costs, and expenses.
_______ **Initial**	**MISSED APPOINTMENTS:** In fairness to other patients and our physicians we require a minimum of 24 hour notice to cancel an appointment. Missing more than three appointments without providing at least 24-hour notice is grounds for discharge from the practice.

My signature below indicates that I have read and agree to the above policies of Dayton Skin Care Specialists.

Signature:____ **Date:**______________

ACKNOWLEDGEMENT OF NOTICES

A copy of the Dayton Skin Care Specialist Notice of Privacy Practices and Notice of Nondiscrimination Practices can be found on our web site, www.daytonskincarespecialists.com under Patient Information / Forms and Policies. A written copy is also available by request at the reception desk.

PRIVACY PRACTICES:
I acknowledge that I have received or been offered a copy of Dayton Skin Care Specialists. Notice of Privacy Practices.
________________ **(Initial)**

I acknowledge my right and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that Dayton Skin Care Specialists may refuse to accommodate my request if it is not reasonable. ________________ **(Initial)**

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account. ________________ **(Initial)**

I authorize my healthcare provider to access my pharmacy data electronically to determine pharmacy benefits, including plan formulary coverage for prescription medications and to download a historic list of all medications prescribed by any provider. ________________ **(Initial)**

PRIVACY INSTRUCTIONS:

Yes ☐ **No** ☐ May we leave detailed messages on your answering machine or voice mail (e.g. test results, billing information, etc.)? If yes, **please provide your preferred phone number:** __________________________________

Yes ☐ **No** ☐ May we discuss details regarding your care, your test results, billing information, or appointment information with someone else, other than you? If yes, please list the name and relationship of each individual below

	Name	Relationship	Phone
1.			
2.			
3.			

You may revoke or update this information at any time, in writing.

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims. Reason for refusal (may be completed by patient or staff): __________________________________
____

NONDISCRIMINATION PRACTICES:
Dayton Skin Care Specialists complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

I acknowledge that I have received or been offered a copy of Dayton Skin Care Specialists. Notice of Nondiscrimination Practices. ________________ **(Initial)**

Signature of Patient or Representative: ____ **Date:**________________

Print Name: ___________________________________

Relationship of Representative/Authority to act on behalf of the Patient: _______________

Medical History

Name:______________________________ Date of Birth:______________________ Today's Date:__________________________
Appointment/Surgery Date: _________________________ Reason for today's visit: ____
Referred by: ______________________________________ Primary Care Physician: ____

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience. **Please also indicate that you <u>have not</u> experienced any of the following conditions by checking the No box.**

Condition	Yes	No	Year	Condition	Yes	No	Year	Condition	Yes	No	Year
Anxiety			Year_____	Crohn's disease			Year_____	Kidney Disease			Year_____
Arthritis			Year_____	Deep Vein Thrombosis			Year_____	Kidney stones			Year_____
Asthma			Year_____	Dementia			Year_____	Liver disease			Year_____
Atrial fibrillation			Year_____	Depression			Year_____	Low blood pressure			Year_____
Bladder			Year_____	Diabetes Type I			Year_____	Migraine headaches			Year_____
Blood clots			Year_____	Diabetes Type II			Year_____	Organ transplant			Year_____
Bowel/Stomach			Year_____	Fainting			Year_____	Pacemaker			Year_____
Bypass surgery (heart)			Year_____	Glaucoma			Year_____	Phlebitis			Year_____
Cancer (other than skin)			Year_____	Heart attack			Year_____	Pulmonary embolus			Year_____
Chest pain			Year_____	Heart murmur			Year_____	Rheumatoid arthritis			Year_____
Chronic cough			Year_____	Hepatitis type ___			Year_____	Seizures/Epilepsy			Year_____
Chronic morning cough			Year_____	High blood pressure			Year_____	Stroke			Year_____
Congestive heart failure			Year_____	Hyperlipidemia			Year_____	Thyroid disease			Year_____
COPD			Year_____	Irregular heart rhythm			Year_____	Tuberculosis			Year_____
Coronary artery disease			Year_____	Irritable bowel syndrome			Year_____	Other:___________			Year_____

Are you immunosuppressed? Yes No
Have you had or have you been exposed to HIV (AIDS)? Yes No
Have you ever been diagnosed with Chronic Lymphocytic Leukemia? Yes No When___________
Cardiologist Name & Phone #___________________________________Current Weight _____ Current Height _____
Do you drink alcohol? Yes No If Yes, ___________drinks per day and what type__________________
Do you use IV drugs? Yes No If Yes, what?______________How much?_______________
Have you ever had dental anesthesia (Novocain)? Yes No Any bad reaction? Yes No

<u>Skin:</u>

When you are exposed to sun do you: Tan only Tan and burn Burn
Have you ever had skin cancer? Yes No If Yes, what type?_________________________
Do you have a history of skin infection? Yes No
Has anyone in your family had skin cancer? Yes No If Yes, relationship?__________________
Do you have a family history of other cancer? Yes No If Yes relationship?_______________Type?_________
Do you have a family history of diabetes? Yes No If Yes, relationship?__________________
Do any of your first-degree relatives have a drug reaction to medication? Yes No If Yes, what type?__________
Do you have a history of any specific skin diseases? Yes No
If Yes, please list____
List any other disease or condition we should know about:____
List surgical procedures you have had in the last 6 months:____

<u>Please answer the following questions:</u>

A. Do you currently smoke? Yes No If Yes, what type and how much?____________ Have you tried to quit? Yes No
If No, did you ever smoke? Yes No What type and how much?_____________
B. Do you bleed easily? Yes No
C. (Women) Are you pregnant or nursing? Yes No Due Date:___________________________
D. Do you have artificial joints, valves? Yes No
E. Are you claustrophobic? Yes No
F. When was your last Influenza Immunization Month/Year ___/___ or N/A
G. When was your last Pneumonia Immunization Month/Year ___/___ or N/A
H. When was your last Colonoscopy Month/Year ___/___ or N/A
I. Female Patients: When was your last Mammogram Month/Year ___/___ or N/A
J. What is your occupation?______________________________ What are your hobbies?____

____

Patient Signature **Date**

MEDICATIONS/ALLERGIES

NAME: ____ **DATE OF BIRTH:** ____________
(FIRST) **(MIDDLE)** **(LAST)**

Are you allergic to any medications: Yes □ No □ If yes, please list below.

1. ____________________ What type of reaction do you experience? ____________________

2. ____________________ What type of reaction do you experience? ____________________

3. ____________________ What type of reaction do you experience? ____________________

CURRENT MEDICATIONS

INCLUDING PRESCRIPTION DRUGS, VITAMINS, HORMONES, ASPIRIN, TYLENOL, ETC.

IF YOU ARE NOT ON ANY MEDICATIONS PLEASE CHECK HERE □

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Patient Signature **Date**