Coastal Dermatology, P.C.
55 Willow Street
Mystic, CT 06355

Daniella Duke, M.D.
(860) 245-0000 TEL
(860) 245-0610 FAX

PATIENT INFORMATION FORMS

THIS INFORMATION IS CONFIDENTIAL

Today's Date______________________
Revised Date______________________
____

General Information

Patient's Name (please print clearly)____
(First) (Middle) (Last)

Social Security # of ***Patient***________-_______-________

Home Phone (________)________________
Work Phone (________)________________
Cell Phone (________)________________

Address____Zip Code______________
(Street) (City, State)

Sex: Male___ Female___ Date of Birth_____/_____/_____ (If applies) Referred by____________________________
Month Day Year (Friend, relative, or Physician)

Employer of Patient________________________________ Address____

If patient is a *minor* (less than 18 years old)
Name of Parent (or Guardian)____________________________ Address____________________________________

If *married*
Name of Spouse _____________________________ Address____

Acknowledgement of Receipt of "Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's "Notice of Privacy Practices". I further acknowledge that a copy of the current notice will be available in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:X____ Date:_________________________________

If not signed by patient, please indicate your relationship to the patient:____

For Office Use Only

☐ Signed form received by:_____________________________________

☐ Acknowledgment refused:

Efforts to obtain:____
Reason(s) for refusal:____

Coastal Dermatology, P.C., Daniella Duke, M.D.

Name of Patient_____________________________________ Age______ Date______________________________

(If referred) Name of Referring Doctor________________________________

Reason for today's visit (chief complaint):____
____
____
____

Allergies (list all; **including allergies to medicine**):____
____

Patient's History. Do you currently, or have you in the past, had problems with any of the following (please check):

	Yes	No
Heart Disease		
High Blood Pressure		
Diabetes		
Thyroid		
Stomach/Bowel		
Liver		
Kidneys		
Eyes		
Ears/Nose/Throat/Mouth		
Blood/Bleeding disorder		
Cancer ___________________		
Immunologic (incl. Hay Fever)		
Arthritis/Muscles/Joints		
Headaches/Seizures		
Psychological disorder		
Lungs (incl. Asthma)		

Skin Problems	Yes	No
- Skin cancer		
- Melanoma		
- Eczema		
- Psoriasis		
- Other_______________		

Prior Surgeries (list)____________________________________
____
____

Other Health Problems:__________________________________
____
____
____
____

Medications currently taking:____

Females: Are you currently pregnant? Yes___ No ___ Are you planning to become pregnant shortly? Yes ___ No ___

Medical History of Patient's Family (Please check the following medical conditions that have occurred in your family):

	Mother	Father	Other
Allergies			
Heart Disease			
High Blood Pressure			
Diabetes/Thyroid			
Stomach/Bowel			
Liver			
Kidneys			
Eyes			
Ears/Nose/Throat/Mouth			
Blood/Bleeding disorder			
Cancer.	. . . .	. . . .	. . . . .What type(s):____________________________________
Immunologic (incl. Hay Fever)			
Arthritis/Muscles/Joints			
Headaches/Seizures			
Psychological disorder			
Lungs (incl. Asthma)			

Patient's Social History

Marital Status _________________________ Do you drink alcohol? Yes___ No___ Frequency_______________
Occupation___________________________ Do you smoke? Yes___ No ___ Frequency_____________________
Hobbies_____________________________ Do you use recreational drugs? Yes___ No___ Frequency_________

Reviewed by:_________________________________ Date__________________ Updated________________________
M.D. Signature

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FINANCIAL RESPONSIBILITIES OF PATIENT

1. I understand that I am financially responsible for all services rendered.
2. **I will present the Check-In receptionist my most recent insurance card at every office visit with accurate and up-to-date insurance information – so that a photocopy can be made for my file.**
3. Late Cancellation Fee: I understand that your office requires at least **24 hours advance notice** for canceling or changing an appointment, and that if I fail to give 24 hours advance notice, ***a late cancellation fee will be charged***. **For Monday appointments, I understand that I need to cancel or make changes by 5:00 PM on Friday**.
4. I understand that if this office participates with my insurance, then this office will bill my insurance company. I understand that I am responsible for: the co-pay (at the time of the visit); the yearly deductible; any co-insurance; non-covered services; and cosmetic services. A late fee of 1½% per month will apply for accounts over 30 days late. You will not be balance billed for covered services.
5. I understand that if this office does not participate with my insurance, or if I do not have health insurance, then I am responsible for payment in full upon completion of the visit. As a courtesy, we may agree to bill your insurance company first, and await their payment, before billing you for any balance due. Generally, this exception is for expensive surgical procedures. Payments made by insurers we do not participate with, for less than the full amount billed, are not considered payment in full, and you would be responsible for the remaining balance.

It has been explained to me that Coastal Dermatology, P.C. (Dr. Daniella Duke) is NOT an authorized TRICARE Provider. I understand that I will be solely responsible for the bill, and that neither I, nor Coastal Dermatology, P.C. will submit a claim for the services provided by Coastal Dermatology, P.C to TRICARE. Despite Coastal Dermatology, P.C.'s status as a Non-Authorized TRICARE Provider, I choose to receive medical care from them.

6. I understand that if I am covered under a gatekeeper or capitated plan, then I need to obtain a referral from the doctor my insurance plan designates as my primary care doctor (internists, family practitioners, and pediatricians) – and our office needs to obtain the referral ***before my visit***. It is my responsibility to make sure this referral is current and complete. If your insurance plan requires a referral, and you have ***not*** obtained one, you have several options:
   a. Call your primary care doctor and have them give you the required referral.
   b. Reschedule today's appointment until you have obtained the referral.
   c. Pay for the visit today, and submit the claim to your insurance company yourself.
7. I understand that if my secondary insurance doesn't apply (for example, if the secondary insurance requires a referral and one has not been obtained), then co-payments and/or annual deductibles are due upon completion of the visit.

I have read and understood the above policies and obligations, and agree to them for all office visits, including future ones:

____________________________ ____________ ____________________________

Signature of Patient (or Parent/Guardian) Date Patient's Name (Please Print)

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ASSIGNMENT OF BENEFITS

For services rendered by Coastal Dermatology, P.C., I hereby assign all medical and/or surgical benefits to which I am entitled, including major medical benefits, to: Coastal Dermatology, P.C., 55 Willow Street, Mystic, CT 06355. This includes Medicare, private insurances, and other health plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be valid as an original. I hereby authorize Coastal Dermatology, P.C. to release all information necessary to secure payment.

____________________________ ____________

Signature of Patient (or Parent/Guardian) Date

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AUTHORIZATION TO LEAVE TELEPHONE MESSAGES

I authorize Coastal Dermatology, P.C. to leave telephone messages for the patient for the following reasons: *reminders* of upcoming appointments; *notification* of missed appointments; *notification* to call our office for test results. *Please check* ( ) *either "Yes" or "No"*: ____Yes ____No

____________________________ ____________

Signature of Patient (or Parent/Guardian) Date