HARKAWAY CENTER
for
DERMATOLOGY AND AESTHETICS

PATIENT INFORMATION (PLEASE PRINT) **ACCOUNT #**			
LAST NAME	FIRST NAME		MIDDLE INITIAL
STREET ADDRESS:	CITY	STATE:	ZIP:
HOME PHONE	CELL PHONE NUMBER	WORK NUMBER	

DATE OF BIRTH	**GENDER (circle one)**	**MARITAL STATUS (circle one)**	**EMPLOYMENT STATUS (circle one)**
Month Date Year	F M	M S D W SEP	Working Retired Military Student ESRD Effective Date _____
SOCIAL SECURITY NUMBER	EMAIL ADDRESS:		OCCUPATION:

PRIMARY CARE PHYSICIAN NAME, ADDRESS AND PHONE NUMBER WOULD YOU LIKE A LETTER SENT TO THEM: **YES / NO**	PHARMACY INFORMATION AND ADDRESS:

Would you like to use APOTHECO home delivery pharmacy that specializes in dermatological products as your primary pharmacy (their expertise is in obtainig the lowest price for your medication) : YES/ NO

RACE	PREFERRED LANGUAGE	ETHNIC GROUP
___ White ___ American Indian ___Asian ___ Black or African American ___ Native Hawaiian/Pacific Islander ___ Other Race	_____ English _____ Spanish _____ Other	_____ Hispanic or Latino _____ Non-Hispanic or Latino

FOR MINORS: PARENT OR RESPONSIBLE PARTY INFORMATION

LAST NAME:	FIRST & MIDDLE NAME	SSN:	RELATIONSHIP:
STREET ADDRESS IF DIFFERENT FROM PATIENT:	CITY	STATE	ZIP:
EMPLOYER:	PHONE NUMBER ( )		
EMPLOYER'S STREET ADDRESS:	CITY	STATE	ZIP:

PRIMARY INSURANCE (POLICYHOLDER IS THE PERSON WHO APPLIED FOR INSURANCE COVERAGE)		
INSURANCE COMPANY NAME:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF SPOUSE CHILD OTHER_____	
POLICYHOLDER'S NAME	DATE OF BIRTH:	SSN#:

SECONDARY INSURANCE (POLICYHOLDER IS THE PERSON WHO APPLIED FOR INSURANCE COVERAGE)		
INSURANCE COMPANY NAME:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF SPOUSE CHILD OTHER_____	
POLICYHOLDER'S NAME	DATE OF BIRTH:	SSN#:

X Signature: _____ Date_____

8001 Route 130 South Delran, NJ 08075 P: 856.461.1400 F: 856.461.2366
1220 Tilton Road Northfield, NJ 08225 P: 609.377.5090 F: 609.241.8449
www.drharkaway.com

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MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE OR CELL PHONE ? _____ YES _____NO

MAY WE EMAIL PERSONAL MEDICAL INFORMATION TO YOU? _____YES _____NO

IF Yes, PLEASE PROVIDE YOUR EMAIL ADDRESS _____

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS OR OTHER CAREGIVERS? ___YES ___NO

#1 NAME_____ RELATIONSHIP_____ PHONE #_____

#2 NAME_____ RELATIONSHIP_____ PHONE #_____

I understand that I am financially responsible for all services rendered. If I am covered by an insurance carrier that requires a referral/authorization from my primary care physician or insurance carrier, it is my responsibility to obtain that referral/authorization prior to my visit. If my Carrier requires direct contact with Harkaway Center for Dermatology and Aesthetics to authorize a referral/authorization I will inform Harkaway Center for Dermatology and Aesthetics of this requirement prior to my visit. FULL PAYMENT is due at time of service, including copays. All balances older than 60 days will be subject to 3% finance charge. All accounts and balances older than 90 days will be transferred over to collection agency and will be subject to additional $30.00 fee. If the account is turned over to a collection agency, that agency has a right to run a credit report when necessary. Any balances not taken care of will be turned over to the National Credit Bureau.

PLEASE CALL TO CANCEL ANY APPOINTMENT YOU CANNOT KEEP AT LEAST 24 HOURS IN ADVANCE. Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per visit. Please help us serve you better by keeping scheduled appointments.

Signature (parent, if patient is a minor) X _____ Date _____

PAYMENT AUTHORIZATION: I authorize insurance payment, if any, directly to Harkaway Center for Dermatology and Aesthetics. I realize I am responsible for non-covered services.

Signature (parent, if patient is a minor) X _____ Date _____

INFORMATION RELEASE: I authorize Harkaway Center for Dermatology and Aesthetics to release to my Insurance Carrier or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to the related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits or Harkaway Center for Dermatology and Aesthetics. Regulations pertaining to Medicare assignment of benefits also apply.

Signature (parent, if patient is a minor) X _____ Date _____

MEDICARE: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance. We do file secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed the balance.

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HIPAA

PATIENT CONSENT FORM

Our notice of privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or other health operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent. In writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

Protected Health information may be disclosed or used for treatment, payment or other health care operations.

The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

The Practice reserves the right to change the Notice of Privacy Practices.

The Patient has the right to restrict the use of their information but the Practice does not have to agree with those restrictions.

The Patient may revoke this Consent in writing at any time, and all future disclosures will then cease.

The Practice may condition receipt of treatment upon execution of this Consent.

This Consent was signed by: _____ _____

SIGNATURE DATE

PRINT NAME - If other than patient Please advise your relationship: _____Relationship: _____

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Patient name _____ D.O.B. _____

History and Intake Form

Past Medical History: (please check all that apply)

❒ Anxiety
❒ Arthritis
❒ Artificial joints
❒ Asthma
❒ Atrial fibrillation
❒ Enlarged Prostate
❒ Bone Marrow Transplantation
❒ Cancer_____ (type) current or past
❒ COPD
❒ Coronary Artery Disease
❒ Depression
❒ Diabetes
❒ End Stage Renal Disease
❒ GERD
❒ Hearing Loss
❒ Hepatitis
❒ High blood pressure
❒ HIV/AIDS
❒ High cholesterol
❒ Hyperthyroidism
❒ Hypothyroidism
❒ Pacemaker
❒ Radiation Treatment
❒ Stroke
❒ Valve Replacement
❒ Other _____
❒ Other _____
❒ None

Past Surgical History: (please check all that apply)

❒ Appendix Removed
❒ Bladder Removed
❒ Breast Biopsy (Right, Left, Bilateral)
❒ Breast Reduction
❒ Breast Implants
❒ Colectomy: Colon Cancer Resection
❒ Colectomy: Diverticulitis
❒ Colectomy: IBD
❒ Coronary Artery Bypass
❒ C -Section
❒ Gallbladder Removed
❒ Heart Valve Replacement
❒ Hysterectomy: Fibroids/ Cancer/ Birth Control
❒ Joint Replacement _____ type
❒ Kidney Removed
❒ Kidney Stone Removal
❒ Lumpectomy (Right, Left, Bilateral)
❒ Mastectomy (Right, Left, Bilateral)
❒ Organ transplant _____ type
❒ Ovaries Removed: Endometriosis/ cancer/ cyst
❒ Prostate Removed: Prostate Cancer
❒ Spleen Removed
❒ Testicles Removed (Right, Left, Bilateral)
❒ None
❒ Other _____
❒ Other _____

Skin Disease History: (please check all that apply)

❒ Acne
❒ Actinic Keratoses
❒ Basal Cell Skin Cancer
❒ Blistering Sunburns
❒ Eczema
❒ Flaking or Itchy Scalp
❒ Hay Fever/Allergies
❒ Melanoma
❒ Poison Ivy
❒ Dysplastic Moles
❒ Psoriasis
❒ Squamous Cell Skin Cancer
❒ None
❒ Other _____
❒ Other _____

Do you wear Sunscreen? ❒ Yes ❒ No

If yes, what SPF? _____

Do you tan in a tanning salon? ❒ Yes ❒ No

History of previous tanning salon use ❒ Yes ❒ No

Do you have a family history of skin cancer? ❒ Yes ❒ No

If yes, which relative(s)/ type? _____

Patient name _____ D.O.B. _____

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
❒ Never smoked	❒ Alcohol: none
❒ Quit: former smoker	❒ Alcohol: less than 1 drink a day
❒ Smokes less than daily	❒ Alcohol: 1-2 drinks a day
❒ Smokes daily	❒ Alcohol: 3 or more drinks a day

Flu shot within last year ❒ Yes ❒ No Pneumonia'vaccination ❒ Yes ❒ No

Advance Care Plan ❒ Yes ❒ No

Do you have a health care proxy in the event you are unable to make your own medical decisions

❒ Yes ❒ No

If so, designee's name: _____, relationship:_____.