Dr. Stacy Frankel: Patient Information Sheet Date:
****

Patient's Name:_____ _____ _____
(First) (Middle) (Last)

Address:_____ Apt #_____

City:_____ State:_____ Zip:_____

Primary phone #: (_____) _____-_____ (home/cell/work/other)

Other phone #: (_____) _____-_____ (home/cell/work/other)

E-mail:_____

Race:	Ethnicity:	Language:
American Indian/Alaskan Native	Hispanic/Latino	English
Asian	Not Hispanic/Latino Spanish	
Black/African American	Other	French/French Creole
Hispanic		Other
Native American		
Other		
Other Pacific Islander		
White		

Sex: _____ Marital Status: _____ Date of Birth: _____

Social Security #: _____-_____-_____ Emergency Contact:
Name:_____
Phone#: _____
Employer:_____ Work #: (_____) _____-_____

Alternate/Out of State Address:_____

Alternate/Out of State Phone#: (_____) _____-_____
****
Primary Insurance Carrier:_____

ID/Policy#:_____ Group#:_____

Secondary Insurance Carrier:_____

ID/Policy#:_____ Group#:_____
****
Primary Care/Referring Physician:_____

Phone#: (_____) _____-_____ Fax#: (_____) _____-_____

Address:_____

SKIN AND CANCER ASSOCIATES

INSURANCE ASSIGNMENT AGREEMENT/PRIVACY NOTICE ACKNOWLEDGMENT

PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through

_____,
(Name(s) of Insurance Company(ies))
and assign directly to Skin and Cancer Associates (SCA) all Insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Beneficiary/Patient Signature Relationship Date

MEDICARE and/or MEDICAID

Lifetime Authorization. Medicare and Medicaid patient certification. Patient certification authorization to release information and payment request.
I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

_____ _____ _____
Patient Signature Patient Name Date

MEDIGAP Note: If you sign here you should also sign for Medicare above
Beneficiary Signature Authorization
I request that payment of authorized Medigap benefits be made on my behalf to SCA for services furnished to me by the physician(s) of SCA. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Beneficiary/Patient Signature Print Beneficiary/Patient Name

_____ _____
HIC (Medicare Number) Medigap Number

_____ _____
Name of Medigap Insurance Company Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____ _____ _____
Patient Signature Patient Name Parent or Authorized Representative (if applicable) Date

Privacy Contact

Other contact information:
The following people, other than a duly designated guardian or conservator, are authorized to discuss my medical condition or billing information with a healthcare professional in this practice:

Name	Relationship	Phone number
_____	_____	(____) _____ - _____.
_____	_____	(____) _____ - _____.
_____	_____	(____) _____ - _____.

I authorize the above persons(s) to discuss my medical information with the healthcare professionals in this practice.

Patient Signature	Patient Name	Date
_____	_____	_____

Pharmacy Information:

Name	Address or Cross Street	Phone Number
_____	_____	(___)____-_____

Stacy Frankel, M.D., P.A.

2951 NW 49TH AVE SUITE 205
LAUDERDALE LAKES, FL 33313
TEL 954-652-0246
FAX 954-652-0471

FINANCIAL RESPONSIBILITY AND YOUR MEDICAL BILL

FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED IS THE RESPONSIBILITY OF THE PATIENT, REGARDLESS OF INSURANCE COVERAGE. WE WILL PROCESS YOUR CLAIMS; HOWEVER, IT IS YOUR INSURANCE COMPANY WHO WILL DETERMINE ELIGIBILITY AND COVERAGE ISSUES. YOU WILL BE REQUIRED TO PAY DEDUCTIBLES, CO PAY'S, CO-INSURANCE AND ANY NON-COVERED ITEMS, DEPENDING ON YOUR INSURANCE PLAN POLICIES AND BENEFITS.

YOU MAY INCUR ADDITIONAL CHARGES FROM THE SERVICES PROVIDED BY OUTSIDE COMPANIES, SUCH AS PATHOLOGY AND LAB CENTERS. THESE ARE BILLED SEPERATLY AND ARE THE RESPONSIBILITY OF THE PATIENT AND/OR INSURANCE COMPANY. ANY QUESTIONS REGARDING THE PROCESSING AND BALANCES DUE SHOULD BE ADDRESSED TO THE COMPANY THE BILL WAS RECEIVED FROM AND ARE NOT THE RESPONSIBILITY OF THE PROVIDER WHO PREFORMED THE SERVICE.

DATE: _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____

Skin and Cancer Associates

Stacy Frankel M.D., P.A. *Board Certified, Dermatology and Cutaneous Surgery*

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your chart. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE____/____/_____ AGE_____

LAST NAME_____ FIRST NAME _____ MIDDLE _____

List current medical problems.

_____

_____

List past surgeries or illnesses.

_____

_____

List current medications and dosages.

_____

_____

List any allergies to medications. Please explain allergic reactions.

_____

List all serious illnesses in your immediate family. (Example: diabetes, skin cancer, etc.)

_____

Do you now or have you had any problems related to the following systems? Circle Yes or No. Please explain any Yes answers in space provided.

Artificial heart valve	Y	N
Heart murmur	Y	N
Current tobacco use	Y	N
Previous tobacco use	Y	N
History of skin cancer	Y	N
Type if known _____		

Pacemaker	Y	N
Artificial joint(s)	Y	N
Current alcohol use	Y	N
Previous alcohol use	Y	N

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other_____		

Dermatologic

Skin rashes	Y	N
Boils	Y	N
Persistent itch	Y	N
Other_____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other_____		

Allergic/Immunologic

Hay Fever	Y	N
Asthma	Y	N
Other_____		

Please read carefully and sign.

I attest that the information provided above in this document is true to the best of my knowledge. I fully understand that any incorrect or missing information can lead to missed or incorrect diagnoses.

Signature_____ Date ___/___/____