Welcome to McKay Dermatology & MedSpa

Name _____ **Today's Date** _____
First Middle Last **Insured patients – Name as it appears on your insurance card**

Date of Birth _____ **Gender:** ☐ Male ☐ Female

Local Address _____
Street Apt# City State Zip Code

Alternate Address _____
Street Apt# City State Zip Code

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Social Security #** _____

Phone Numbers: Home _____ **Work** _____ **Cell** _____

Party Responsible for Payment _____ **Address** _____

Insured Name _____ **Insured Date of Birth** _____

Insured Social Security # _____ **Relationship to Patient** _____

Primary Insurance Carrier _____

Secondary Insurance Carrier _____

Name and Location of Pharmacy You Use _____

Who Referred You to Us? _____

E-Mail Address _____

IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED

INSURANCE RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Elizabeth McKay, MD, DBA McKay Dermatology & MedSpa, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

FINANCIAL STATEMENT
Payment is required for all services at the time they are rendered unless you are covered by an insurance plan in which we participate. For those patients, applicable co-payments & deductibles will be collected. We accept payment in the form of cash, check or credit card. In the event of major procedures, your insurance coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, the collection fee will be added to your account. Your signature below signifies your understanding & willingness to comply with this policy.

PRIVACY POLICY
I have been offered and have inspected a copy of McKay Dermatology's Notice of Privacy Practices. I understand it and am willing to comply with this policy.

_____
Signature Relationship Date

MEDICAL RECORDS RELEASE:
I hereby authorize McKay Dermatology & MedSpa to obtain medical records, x-rays, lab results, scans, pathology slides from any physician, hospital, clinic where I have been treated.

I also authorize McKay Dermatology & MedSpa to release medical records, x-rays, lab results, scans to:

_____(Referring, Family or Primary Physician).
Physician Name

_____
Signature Date

Do we have your permission to:

Leave a detailed message on your answering machine at home?	Yes	No
Leave a detailed message on your cell phone?	Yes	No
Leave a detailed message at your place of employment?	Yes	No
Discuss your medical condition with a member of your household?	Yes	No

If yes, whom: _____ Relationship _____

What is your reason for today's visit? _____

_____

Are you currently experiencing any of the following? Changing Moles or Bleeding Lesions

Medical History: (please circle all that currently apply)

Anxiety	COPD	HIV/AIDS	Radiation Treatment
Arthritis	Coronary Artery Disease	Hypercholesterolemia	Seizures
Asthma	Depression	Hyperthyroidism	Stroke
Atrial Fibrillation	Diabetes	Hypothyroidism	Valve Replacement
BPH	End Stage Renal Disease	Leukemia	None
Bone Marrow Transplant	GERD	Lung Cancer	Other: _____
Breast Cancer	Hepatitis	Lymphoma	_____
Colon Cancer	Hypertension	Prostate Cancer	_____

Surgical History: Have you had any surgeries on the following organs? (please circle all that apply)

Appendix Removed	PTCA (Angioplasty)	Ovaries Removed: Endometriosis
Bladder Removed	Mechanical Valve Replacement	Ovaries Removed: Ovarian Cancer
Mastectomy ☐ Right ☐ Left ☐ Both	Biological Valve Replacement	Ovaries Removed: Cyst
Lumpectomy ☐ Right ☐ Left ☐ Both	Heart Transplant	Prostate Removed: Prostate Cancer
Breast Biopsy ☐ Right ☐ Left ☐ Both	Hysterectomy: Fibroids	Prostate Biopsy
Breast Reduction	Hysterectomy: Uterine Cancer	TURP
Breast Augmentation	Joint Replacement, Knee ☐ Right ☐ Left ☐ Both	Skin Biopsy
Colectomy: Colon Cancer Resection	Joint Replacement, Hip ☐ Right ☐ Left ☐ Both	Basal Cell Cancer Surgery
Colectomy: Diverticulitis	Kidney Biopsy	Squamous Cell Cancer Surgery
Colectomy: IBD	Kidney Removed ☐ Right ☐ Left	Melanoma Surgery
Gallbladder Removed	Kidney Stone Removed	Spleen Removed
Coronary Artery Bypass	Kidney Transplant	Testicles Removed ☐ Right ☐ Left ☐ Both

Other _____

Skin Disease History: (please circle all that apply)

Acne	Blistering Sunburns	Hay Fever/ Allergies	Melanoma*
Actinic Keratosis	Dry Skin	Precancerous Moles	None
Asthma	Eczema	Psoriasis	Other _____
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Squamous Cell Skin Cancer	_____

***If you have had a malignant melanoma, please answer the following:**

Level of melanoma: (I, II, III, IV, V) _____ Depth of melanoma: _____mm

Did you have any lymph nodes tested? _____ If yes, results _____

Date of melanoma surgery _____

Have you had a PET scan? _____ If yes, results _____

Do you have an oncologist? _____ If yes, who? _____

Do you wear Sunscreen: ☐ Yes ☐ No If Yes, what SPF? _____ Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

Medications (Please enter all current medications, or if you have a list with you we can make a copy of it)

_____

_____

Allergies: (Please enter all allergies)

_____

_____

Social History:

Do you *(or did you ever)* smoke? ☐ Yes ☐ No If yes: ☐ daily ☐ not daily ☐ in the past

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

What are your hobbies? _____

What is *(or was)* your occupation? _____

Are You Interested in any of the Following?

_____ Skin Rejuvenation	_____ Botox®	_____ Fillers – Juvederm®, Restylane®
_____ Laser Resurfacing	_____ Laser Treatment for Facial Vessels	_____ Brown Spot Removal
_____ Skin Tightening	_____ Scar Improvement	_____ Skin Care Products
_____ Skin Tag Removal	_____ Mole Removal	_____ Jane Iredale Skin Care Makeup

Thank You for Allowing Us to Assist in the Care of Your Skin!

McKay
DERMATOLOGY & MEDSPA

Your Privacy Is Important to Us

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have received a copy of the Notice of Privacy Practices of McKay Dermatology and MedSpa. I hereby authorize, as indicated by my signature below, McKay Dermatology and MedSpa to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____
Print Name(Circle one: Patient/Parent/Legal Guardian) Address

_____ _____
Signature Date

Please check your preferred means of communication:
Pt. Initials

_____ You may contact me/leave message at my home telephone number:_____

_____ You may contact me/leave message on my mobile telephone number: _____

_____ You may contact me/leave message on my work telephone number:_____

_____ You may send me an unencrypted email at: _____

_____ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____
   Name/Relationship
2. _____Date Added / Removed: _____
   Name/Relationship
3. _____Date Added / Removed: _____
   Name/Relationship

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

Please answer Below by Circling YES or NO

YES NO Have you ever recently joined a Medicare HMO? If yes, indentify_____

YES NO Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?

YES NO Are you covered by a HMO/PPO which makes Medicare secondary?

YES NO Is this illness covered by the VA (Veteran's Administration)?

YES NO Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?

YES NO Is this illness due to an automobile accident?

YES NO Is this illness due to an injury at work?

YES NO Are you receiving Medicaid?

Lifetime Medicare Part B - Signature Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers, or to any laboratory, or to the billing agent of Dr. Elizabeth McKay (DBA McKay Dermatology), any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medial insurance benefits either to myself or the party who accepts assignments.

For Services Starting Date:_____ Signature of Insured_____
(Today, if not specified)

MEDIGAP PATIENTS ONLY:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medial information to release to the MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____
Signature as it appears on MEDIGAP Card

Please present your insurance cards to the receptionist.