



Medical History and Progress Note Form

Name: _____ Date: _____

Age _____ Ethnicity/Race _____ Male/Female _____ Pregnant _____
(optional) (yes/no)

Medical Illness (es) _____

Current Medication (s) _____

Current Dermatology Medication (s) _____

Past Dermatology Medication (s) _____

Medication Allergies _____

Skin/Hair/Nail Concerns: (example: skin rash on arm, hair loss, acne)

1. _____

2. _____

3. _____



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DERMATOLOGY AND DERMATOLOGIC SURGERY

PATIENT INFORMATION

Name: _____ Date of Birth: _____
SS#: _____ Married/Single _____ M/F _____
Home Address: _____ City: _____
State/Zip: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____
Email Address: _____
Employer's Name: _____
Address: _____
Primary Doctor: _____

INSURANCE INFORMATION

IF YOUR INSURANCE REQUIRES THAT YOU BRING IN A REFERRAL, IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH A VALID REFERRAL FOR YOUR VISITS. PLEASE CHECK THE EXPIRATION DATE.

Primary Insurance: _____
ID Number: _____ Group Number: _____
Address: _____
Policy Holder () self () Spouse Name _____
SS#: _____ DOB: _____

Secondary Insurance: _____
ID: _____ Group Number: _____
Policy Holder: _____ SS: _____ DOB: _____

PLEASE BE SURE TO GIVE YOUR DRIVER'S LICENSE & INSURANCE CARDS TO THE RECEPTIONIST. I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS ACCURATE AND I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO PROCESS ANY CLAIMS THROUGH MY HEALTH INSURANCE.

SIGNATURE _____ DATE _____

PATIENT PRIVACY & PRACTICE POLICIES (PLEASE INITIAL ALL ITEMS BELOW)

PATIENT PRIVACY POLICY: I have reviewed a copy of the practice privacy policies. I understand that the practice may change this privacy policy in the future. _____ Initials

MEDICAL POLICY: I understand that this office employs **University Trained** board certified **PHYSICIAN ASSISTANTS** and that they may be involved in rendering portions of my medical care along with an attending physician. _____ Initials

MEDICAL RECORDS RELEASE POLICY: The practice requires a \$25.00 fee for researching, copying, and to mail medical record (if applicable). This fee is due in full prior to their release. _____ Initials

FINANCIAL POLICY: We are dedicated to providing you with the best possible care and service and your understanding of our financial policies is an essential element of your care and treatment. To assist you, we have the following financial policy. Unless either you or your health coverage carrier has made other arrangements in advance, full payment is due at the time of service. **For your convenience we accept cash, checks (minimum \$20.00), Visa, MasterCard and American Express.** If you have any questions; please feel free to discuss them with our staff. _____ Initials

INSURANCE POLICY: We have made prior arrangements with many insurance health plans. We will bill those plans with which we have an agreement and will collect co-pays or a deductible at the time of service when you arrive for your appointment. In the event your health plan determines a service to be non-covered, you will be responsible for the complete charge. Subsequently, we will bill you directly and payment is due upon receipt of the statement. We will also bill your health plan for all service we provide in the hospital. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. _____ Initials

CANCELLATION POLICY: To avoid a fee of \$25.00 or \$50.00(surgery appt.), please do the following:

*Allow 24 hours advance notice when canceling a follow up appointment (return office appt.) _____ Initials

*Allow 48 hours advance notice when canceling a surgery appointment. _____ Initials

To avoid a cancellation fee of \$50.00 please allow 48 hours advance notice when canceling a weekend (Saturday) surgery appointment. _____ Initials

FOR YOUR CONVENIENCE, PLEASE FEEL FREE TO VISIT OUR WEBSITE at www.CallenderSkin.com TO RESCHEDULE/CANCEL YOUR APPOINTMENT (CONTACT US PAGE)

I have read and understand the policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

SIGNATURE OF PATIENT/PARENT

PRINT NAME OF POLICY HOLDER

PRINT NAME OF PATIENT (MINOR)

DATE