Kansas City Skin & Cancer Center, LLC **Patient Information Form**

(All information is confidential.)

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial) | Date of Birth | Sex | Social Security #

Street Address | Apt# | City | State | Zip

Home Phone | Work Phone | Cell Phone | Email Address

Marital Status (please circle): Single Married Divorced Widowed

May we leave a message on your home answering machine? **Y N**

May we leave a message for you at work to call us? **Y N**

May we discuss your medical condition with another person? **Y N** If yes, with whom: _____

May we have marketing information sent to you by email about our personnel, products and services? **Y N**

INSURANCE INFORMATION

Primary Insurance | Primary Policy Holder | DOB | Social Security # | Policy Holder's Employer

Patients Relationship to Primary Policy Holder:

Secondary Insurance | Secondary Policy Holder | DOB | Social Security # | Policy Holder's Employer

Patients Relationship to Secondary Policy Holder:

LANGUAGE/ETHNICTY/RACE (please circle)

Preferred Language: English or Other _____ Ethnicity: Not Hispanic or Latino/Hispanic or Latino/Unknown

Race: American Indian or Alaska Native/ Black or African American/White/Other Race _____

EMERGENCY CONTACT

Emergency Contact | Relationship to Patient | Phone Number

RESPONSIBLE PARTY (If patient is a minor. We do not bill the absent parents, the adult present with the patient is the responsible party.)

Responsible Party | Relationship to Patient | Social Security Number

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

PRIMARY PHYSICIAN (please include location or group) **REFERRING PHYSICIAN (please include location or group)**

IMPORTANT INFORMATION/AUTHORIZATION

I hereby authorize Kansas City Skin & Cancer Center to release any information necessary to secure payment on behalf or on behalf of my dependent. I authorize payment directly to Kansas City Skin & Cancer Center for treatment on any and all services rendered. I further understand that I am responsible for all fees not paid by my insurance and the balance is due within 30 days receipt of a patient statement. If my account balance becomes delinquent and is forwarded to an attorney or collection agency, I am responsible for any collection and interest fees, attorney fees and court costs. I certify all information given is try and accurate. A copy of my signature is as valid as the original.

Signature: **Date:**

ACKNOWLEDGEMENT OF HIPAA PRIVACY ACT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, to obtain payment from third-party payers and to conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Kansas City Skin & Cancer Center's Privacy Practices available in the waiting room or upon my request containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact the Privacy Manager to obtain a current copy of the Notice. I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound by such restrictions.

Signature: **Date:**

KANSAS CITY SKIN & CANCER CENTER LLC

Patient Name: _____ **Date of Birth:** _____
(Please Print)

How did you hear about us? (circle one)

- Primary Care doctor. Doctor's name: _____
- Referred by a doctor. Referring doctor's name: _____
- Friend/Family: _____
- Internet
- Self
- Other: _____

Preferred Pharmacy

Name: _____

Address: _____

_____

Phone: _____

History and Intake Form

Past Medical History: (please circle all that apply)

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

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Other

Other _____

Skin Disease History: (please circle all that apply)

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

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)? _____

Any other family history: _____

Medications: (please list all current medications <u>to include over the counter medications</u> – WITHOUT DOSE)

_____
_____
_____
_____
_____
_____
_____
_____

Allergies: (please list all allergies to medications)

_____
_____
_____
_____
_____
_____
_____
_____

Social History: (please circle all that apply)

Cigarette Smoking:

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoked

Sexual History:

- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Illicit Drug Use:

- Drug Use
- IV Drug Use

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:

- I feel safe at home.
- I do not feel safe at home.

Other _____

None

Review of Systems: Are you currently experiencing any of the following?
(please check Yes or No for the following)

Symptom	Yes	No
Immunosuppression		
Anxiety		
Problems with scarring		
Fever or chills		
Headaches		
Night sweats		
Unintentional weight loss		
Blurry vision		
Depression		
Joint aches		
Hay fever		
Muscle weakness		
Problems with healing		
Changing mole		

Alerts: Are you currently experiencing any of the following?
(please check Yes or No for the following)

Alert	Yes	No
Pacemaker		
Defibrillator		
Artificial heart valve		
Artificial joint within the past two years		
Allergy to lidocaine		
Allergy to latex		
Pregnancy or planning a pregnancy		
Premedication prior to procedures		
Allergy to adhesive		
Blood thinners		