Skin and Cancer Center of Scottsdale & Carefree Dermatology

Dr. Joseph Machuzak **Dr. Glenn Yarbrough** **Robert Casquejo PA-C** **Dr. Mark Meyers**

Patient Registration & Medical History **Date:** _____

Name_____**SSN#**_____

Date of Birth_____ **Gender** ☐ **Male** ☐ **Female** **Marital Status** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Address 1 _____**City** _____**State** _____ **Zip**_____

Address 2 _____**City** _____**State** _____ **Zip**_____

Phone (*check ✓ preferred contact number*)

Home ☐ _____ **Cell** ☐ _____ **Work** ☐ _____

Email_____ **May we send information to you at this email address** ____**Yes** ____**No**

Employer _____ **Employer Address** _____

Primary Care Physician_____**PCP Phone** _____

Referring Physician ☐ **PCP or** ☐ **Other Physician Name** _____ **Phone** _____

If not referred, how did you hear about us? ☐ **Website** ☐ **Physician** _____☐ **Current Patient** ☐ **Other**_____

Pharmacy _____ **Phone** _____ **Address**_____

Skin and Cancer Center of Scottsdale has my permission to give Biopsy/Lab Result or other messages:

☐ **To me** ☐ **To other family members** ☐ **All of the options**
☐ **To my spouse** ☐ **on my answering machine**

GUARANTOR (*If Guarantor is the Patient, Check Here ☐ and Skip to Next Section)*

Last Name: _____**First:** _____**MI:** _____**Date of Birth:** ___/____/_____

Address: _____**City:** _____**State:** _____**Zip:** _____

Home Phone: _____ **Work Phone:**_____**SSN#:**_____

Sex: _____ **Marital Status:** _____ **Occupation:** _____

Relationship to Patient ☐ **Spouse** ☐ **Parent** ☐ **Legal Guardian**

INSURANCE *Please present insurance card(s) with this form*

Primary Insurance : _____**Policy Holder :** _____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other Date of Birth:** ____/_____/_____ **SSN:**_____

Employer's Name: _____ **Policy#:** _____**Group#:**_____

Secondary Insurance: _____**Policy#:** _____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** **Date of Birth:** ____/_____/_____**SSN:** _____

Employers Name: _____**Policy#:** _____**Group#:** _____

If you are over 65 and Medicare is secondary, Please list reason:

EMERGENCY CONTACT

Name: _____**Phone:** (_____)_____-_____**Relationship:** _____

Name: _____**Phone:** (_____)_____-_____**Relationship:** _____

Federal Health Guidelines require we ask these questions. You may defer by checking here_____

Ethnicity (check)	☐ **Hispanic or Latino**	☐ **Not Hispanic or Latino**	☐ **Unspecified**
Race (check one)	☐ **American Indian/ Alaskan Native**	☐ **Asian**	☐ **Native Hawaiian/ Other Pacific Island**
	☐ **Black/African American**	☐ **White**	☐ **Unspecified**
Preferred Language	☐ **English**	☐ **Spanish**	☐ **Unspecified**

SCCS PATIENT MEDICAL HISTORY

NAME: _____ **DATE:** _____

MEDICATION ALLERGIES: ☐ None ☐ Yes (please list)_____

_____

Are you sensitive to ☐ Foods ☐ Environment (dust/pollen/pets) ☐ Bandages ☐ Topical Neosporin

HAVE YOU EVER HAD a bad reaction to "NUMBING" MEDICINE (Novocaine, Lidocaine)? ☐ No ☐ Yes

CURRENT MEDICATIONS (including over-the-counter remedies, vitamins, herbals):

1)_____ **2)**_____ **3)**_____

4)_____ **5)**_____ **6)**_____

Are you required to take antibiotics prior to dental or surgical procedures? ☐ No ☐ Yes

Do you have/ have you ever had the following conditions? Please check either yes or no, and denote a family history of the condition by checking where indicated:

LUNGS:	YES	NO	FAMILY HISTORY
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Asthma	☐	☐	☐
Chronic cough	☐	☐	☐
Shortness of breath	☐	☐	☐
Wheezing	☐	☐	☐
Allergies	☐	☐	☐
CARDIOVASCULAR:			
High blood pressure	☐	☐	☐
Chest Pain	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
Blood clots (DVT/PE)	☐	☐	☐
Pacemaker	☐	☐	☐
HEMATOLOGY:			
Leukemia	☐	☐	☐
Bleeding disorders	☐	☐	☐
Cancer	☐	☐	☐

If yes, what type?_____

_____

GASTROINTESTINAL	YES	NO	FAMILY HISTORY
Crohn's or Colitis	☐	☐	☐
Ulcers	☐	☐	☐
Celiac Disease	☐	☐	☐
Cirrhosis	☐	☐	☐
OTHER SYSTEMMIC:			
Diabetes	☐	☐	☐
Thyroid disease	☐	☐	☐
Kidney Disease	☐	☐	☐
Dialysis	☐	☐	☐
Arthritis	☐	☐	☐
Convulsions/seizures	☐	☐	☐
Lupus	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Nerve disease	☐	☐	☐
REPRODUCTIVE			
Polycystic ovaries	☐	☐	☐
Yeast Infections	☐	☐	
INFECTIOUS DISEASE:			
Hepatitis	☐	☐	
HIV	☐	☐	
Syphilis	☐	☐	

List any other diseases/ conditions: _____

SKIN:

Have you ever had skin cancer? ☐ Yes ☐ No **What type**_____

Has anyone in your family had skin cancer? ☐ Yes ☐ No **What type?** _____

Do you have a history of any specific skin diseases? ☐ Yes ☐ No **What type?** _____

_____

Do you have problems with wound healing? ☐ Yes ☐ No

Do you develop large scars (keloids) after surgery? ☐ Yes ☐ No

SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes ☐ No **How many drinks per day?**_____

Do you smoke? ☐ Yes ☐ No **How often?** _____**For how long?**_____

Do you use any recreational drugs? ☐ Yes ☐ No **What kind?**_____

What is your occupation? _____

Completed by : ☐ Patient ☐ Guardian/Parent ☐ Medical assistant _____
Initials

_____ _____

Patient signature **Date** **Provider Signature** **Date**

Patient Name _____ **DOB:**_____

PREVIOUS SURGERIES

_____Date: _____ _____Date: _____

_____Date: _____ _____Date: _____

CONSENT TO THE USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

I hereby consent to the use and disclosure of personal health information by Skin & Cancer Center of Scottsdale, its workforce, and its business associates for the purposes of carrying out treatment, health care operations, and obtaining insurance payment. A copy of the Notice of Privacy Practices for Protected Health Information (Privacy Notice) has been made available to me and it describes my rights as well as the potential uses and disclosure of my protected health information by Skin & Cancer Center of Scottsdale.

- You have the right to revoke this consent at any time by notifying the office in writing, except to the extent the office has taken action and reliance upon your consent.
- You have the right to request to restrict the manner in which your protected health is used. The office is not required, however, to agree to such requested restrictions. If the office agrees to the requested restriction, our office will honor the request and it will be binding.
- We have reserved the right to change the privacy practices described in the Privacy Notice in accordance with the law.
- You may obtain a copy of the Privacy Notice and revisions by making such request in writing or in person at our office.

_____ _____ **20** _____

Patient or Guardian's Signature **Date**

RELEASE OF PROTECTED HEALTH INFORMATION

Do you authorize this office to discuss your care or treatment with any parties besides yourself ? ☐ Yes ☐ No

If YES, list name and relationship to you: _____ _____

RELEASE AND ASSIGNMENT

I, the undersigned have insurance coverage with _____
and assign directly to Skin & Cancer Center of Scottsdale all medical benefits. I understand that I am financially responsible for any charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I am responsible to pay any deductible and /or co-payment and non-covered services under the terms of my insurance. I understand that any payments, which are due, starting 30 days after insurance coverage has been completed, will be charged a $3.00 monthly late service charge: (or) at a rate of 1.5 % interest per month on unpaid balance, whichever is larger. I understand that I am financially liable in the event of non-payment: I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

_____ _____ **20** _____

Insured or Guardian's Signature **Date**

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits to be made directly to Glenn Yarbrough M.D., and Robert Casquejo PA-C on my behalf for any service furnished by that physician or PA in the office. I authorize any holder of medical information about me to release to CMS and its agents needed to determine these benefits payable for related services. I understand my signature request that be made and authorize release of medical information necessary to pay claim. In Medicare assigned cases, the physician or Physician Assist. agree's to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible for deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon charge determination of the Medicare carrier.

_____ _____ **20** _____

Beneficiary's Signature **Date**

NON-INSURANCE (CASH) AND / OR COSMETIC PATIENTS

I understand that payment in full is expected at Time of Service for all services performed by Skin & Cancer Center of Scottsdale. I also adhere to the current policy of Skin & Cancer Center of Scottsdale regarding collection fees incurred to collect balance in full.

_____ _____ **20** _____

Patient or Guardian's Signature **Date**

Skin and Cancer Center of Scottsdale
Carefree Dermatology

Patient Name: _____DOB: _____

INSURANCE ASSIGNMENT AND FINANCIAL POLICY

PAYMENT POLICY

MEDICARE:
We are participating providers of the Medicare program. We will accept assignment of all claims. Patients are responsible for meeting their annual deductible and co-pays at the time of service. We do file with secondary supplement carriers.

HMO, PPO, OTHER MANAGED CARE PATIENTS:
You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services at the time of service. Patients without the required referral from your PCP at the time of appointment will be asked to reschedule. If you prefer to be seen without the required referral, payment will be due at the time of service.

COMMERCIAL PATIENTS:
Patients who are covered by private, commercial plans, in which our physician is not contracted, are responsible for all fees. The balance left after payment from your insurance will be billed to you.

INSUFFICIENT FUNDS/RETURNED CHECK POLICY
I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payments on my account thereafter and I will be obligated to pay a returned check fee of $30.00.

PAYMENT IS DUE AT THE TIME OF SERVICE
I understand that office visit charges are payable on the day services are rendered. I authorize Skin & Cancer Center of Scottsdale to bill my insurance company. Regardless of insurance coverage, I am responsible to pay all fees in a timely manner. I understand that my contract is between Dr. Glenn Yarbrough, Robert Casquejo PA-C, Dr. Mark Meyers or Dr. Joseph Machuzak. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand I am financially liable in the event of non-payment. I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

_____ _____ **20** _____
Patient or Guardian's Signature **Date**

_____ _____**20** _____
Staff Signature **Date**