Silverton Skin Institute

DISEASES AND REVISIONS OF THE SKIN

AUTHORIZATION TO TREAT

I, the undersigned, authorize Dr. Silverton and his staff to perform any procedures and take any photographs as necessary to diagnose and treat my conditions.

Patient Signature: _____ **Date:** _____

AUTHORIZATION TO TREAT A MINOR

I, the undersigned, authorize Dr. Silverton and his staff to perform any procedures and take any photographs as necessary to diagnose and treat my child/minor's conditions.

Patient Signature: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

I, the undersigned, authorize the release of any medical or insurance information to the Social Security Administration and Health Care Financing Administration or the stated insurance company necessary to process insurance claims for services rendered by this facility. I hereby authorize my insurance company to distribute the payment of my (or my dependants) medical coverage directly to the provider rendering services. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature: _____ **Date:** _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I, authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature: _____ **Date:** _____

PAYMENT POLICY

Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate.

Any applicable co-payments, co-insurances and/or deductibles will be collected at the time of service. We accept payment in the form of cash, check or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/oall charges not paid for by insurance company. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is performed, it is the patient's financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such procedure. Your signature below signifies your understanding and willingness to comply with these policies.

A $25.00 "No Show" fee will be charged to your account if you fail to cancel or re-scehdule your appointment at least 24 hours in advance. While we will make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment.

A fee will be charged for any returned checks.

INSURANCE COVERAGE

If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring it with you prior to your visit. If you do not have a referral number, and your insurance company requires it, it may be necessary to reschedule your appointment.

I have read the Payment Policy and Insurance coverage described above. I understand and agree to all its provisions.

Patient Signature: _____ **Date:** _____

Silverton Skin Institute

DISEASES AND REVISIONS OF THE SKIN

Kimball Silverton, D.O.
Dermatology • Cosmetic Surgery

8245 N. Holly Rd., Suite 101
Grand Blanc, MI 48439
Phone: (810) 606-7500 • Fax: (810) 606-9600

PATIENT INFORMATION

Patient Name _____ _____ _____
First Middle Last

Mailing Address _____ _____ _____ _____
Street or PO Box City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____ / ____ / ____ Social Security # _____

Employer _____

(Check One) ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

RESPONSIBLE PARTY (Person Responsible for Payment if different from Patient)

Name _____ _____ _____ Relationship to Patient: _____
First Middle Last

Mailing Address _____ _____ _____ _____
Street or PO Box City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____ / ____ / ____ Social Security # _____

Employer _____

IN CASE OF AN EMERGENCY

Name of friend/relative not residing with you: _____

Relationship to patient: _____

Address _____

Day phone _____ Evening phone _____ Cell Phone _____

INSURANCE INFORMATION (Copy of insurance card is required.)

PLEASE CHECK ONE: INSURANCE ☐ SELF PAY ☐

Primary Insurance Name _____

Primary Policy Holder Name (if different from patient) _____ Date of Birth ____ / ____ / ____

Secondary Insurance _____

Secondary Policy Holder Name (if different from patient) _____ Date of Birth ____ / ____ / ____

Primary Care Physician _____ Phone: _____

HIPPA REQUIREMENTS

I have been offered the Health Insurance Portability and Accountability Act (HIPPA) to read. Our book is located at the front desk. Please provide names of persons that we may release your medical information to:

_____ _____ _____ Emergency Contact ☐Yes ☐No
Name Phone Relationship

_____ _____ _____ Emergency Contact ☐Yes ☐No
Name Phone Relationship

May non-medical information be left on your answering machine? ☐Yes ☐No Don't have one ☐

May we call you at work? ☐Yes ☐No Don't work ☐

Patient Signature: _____ **Date:** _____

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SURGICAL HISTORY (CONTINUED)

- ☐ Heart: Coronary Artery Bypass Surgery, Valve Replacement, PTCA, Heart Transplant
- ☐ Ovaries (Oopherectomy): Endometriosis, Ovarian Cyst, Ovarian Cancer
- ☐ Skin: Skin Biopsy, Basal Cell Carcinoma, Squamous Cell Carcinoma, Abnormal Mole, Melanoma
- ☐ Testicles (Orchidectomy)
- ☐ Joint Replacement: R/L/Both Knees, R/L/Both Hip
- ☐ Kidney: Kidney Biopsy, Nephrectomy, Transplant, Kidney Stone Removal
- ☐ Prostate (Prostatectomy): Prostate Cancer, Prostate Biopsy
- ☐ Spleen (Splenectomy)
- ☐ Uterus (Hysterectomy): Fibroids, Uterine Cancer

PAST MEDICAL HISTORY

- ☐ Acne
- ☐ Basal Cell Skin Cancer
- ☐ Eczema
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Actinic Keratoses
- ☐ Blistering Sunburn
- ☐ Flaking or Itchy Scalp
- ☐ Poison Ivy
- ☐ Squamous Cell Skin Cancer
- ☐ Asthma
- ☐ Dry Skin
- ☐ Hay Fever/Allergies
- ☐ Precancerous Moles

Do you wear sunscreen? ☐ YES ☐ NO SPF _____

Do you tan in a tanning salon? ☐ YES ☐ NO

Family History of Melanoma? ☐ YES ☐ NO If yes, which relative? _____

SOCIAL HISTORY

- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner

DRUG USE

☐ YES ☐ NO

SMOKING STATUS

☐ Current smoker (some/everyday) ☐ Former smoker ☐ Never smoked

REVIEW OF SYSTEMS

- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ Allergy to topical antibiotic ointments
- ☐ Allergy to lidocaine
- ☐ Nausea or vomiting with antibiotics
- ☐ Immunosuppression
- ☐ Abdominal pain
- ☐ Bloody Urine
- ☐ Cough
- ☐ Headaches
- ☐ Muscle weakness
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Defibrillator
- ☐ Premedication prior to procedures
- ☐ Blood Thinners
- ☐ Rapid heartbeat with epinephrine
- ☐ Problems with bleeding
- ☐ Changing mole
- ☐ Anxiety
- ☐ Blurry Vision
- ☐ Depression
- ☐ Hay fever
- ☐ Neck stiffness
- ☐ Shortness of breath
- ☐ Unintential weight loss
- ☐ Artificial joints (within past 2 years)
- ☐ Allergy to adhesive
- ☐ Pregnancy or planning a pregnancy
- ☐ Yeast infections with antibiotics
- ☐ Problems with scarring (keloid)
- ☐ Rash
- ☐ Bloody stool
- ☐ Chest Pain
- ☐ Fever or chills
- ☐ Joint aches
- ☐ Night sweats
- ☐ Sore throat
- ☐ Wheezing

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Dermatology • Cosmetic Surgery

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Grand Blanc, MI 48439
Phone: (810) 606-7500 • Fax: (810) 606-9600

Name: _____ Date of Birth : _____

PHARMACY

Name: _____ Phone : _____

Address: _____

MEDICATIONS _____

_____

_____

ALLERGIES

Type of reaction: difficulty breathing/swelling of lips/diarrhea/fatigue/nausea/hives/liver

toxicity/rash/other: _____

PAST MEDICAL HISTORY

- ☐ **Anxiety**
- ☐ **Asthma**
- ☐ **Benign Protate Hypertrophy**
- ☐ **Breast Cancer**
- ☐ **Congested Heart Failure/Emphysema**
- ☐ **Depression**
- ☐ **End Stage Renal Disease**
- ☐ **Hearing loss**
- ☐ **Hypertension (High Blood Pressure)**
- ☐ **Hypercholesterolemia**
- ☐ **Hypothyroidism**
- ☐ **Lung Cancer**
- ☐ **Prostate Cancer**
- ☐ **Seizures**
- ☐ **Arthritis**
- ☐ **Atrial Fibrillation (Irregular Heartbeat)**
- ☐ **Bone Marrow Transplantation**
- ☐ **Colon Cancer**
- ☐ **Coronary Artery Disease**
- ☐ **Diabetes**
- ☐ **Gastroesphogeal Reflux Disease**
- ☐ **Hepatitis**
- ☐ **HIV/AIDS**
- ☐ **Hyperthyroidism**
- ☐ **Leukemia**
- ☐ **Radiation Treatment**
- ☐ **Stroke**

SURGICAL HISTORY

- ☐ **Appendix (Appendectomy)**
- ☐ **Breast: Mastectomy (Right/Left/Both)**
- ☐ **Breast Biopsy**
- ☐ **Breast Implants**
- ☐ **Gallbladder (Cholecystectomy)**
- ☐ **Bladder (Cystectomy)**
- ☐ **Breast: Lumpectomy (Right/Left/Both)**
- ☐ **Breast Reduction**
- ☐ **Colon (Colectomy): Colon Cancer Resection/ Divertcultixs/ Inflammatory Bowel Disease**