KANSAS CITY **SKIN & CANCER** CENTER LLC

PATIENT INFORMATION
(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? **YES NO**

May we leave a message for you at work to call us? **YES NO**

May we discuss your medical condition with another person? **YES NO** If yes, with whom:

Would you like to access your patient portal information? **YES NO**

INSURANCE INFORMATION

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

Patient's Relationship to Primary Policy Holder:

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

Patient's Relationship to Secondary Policy Holder:

LANGUAGE/ETHNICITY/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 absent parents; the adult present with patient is 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:

ACKNOWLEDGMENT 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:

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise that require you to cancel your appointment. Therefore, if you must cancel your appointment, please provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours in advance, we are unable to offer that slot to other patients.

Office appointments that are canceled with less than 24 hours notice may be subject to a $35 Cancellation fee.

Patients who do not come to their scheduled appointment without a call to cancel the appointment will be considered a No Show. Patients who No Show two (2) or more times in a 12-month period may be dismissed from the practice and denied any future appointments. Patients may also be subject to a $35 No Show fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived with management approval.

Our practice firmly believes that a good patient/provider relationship is based on understanding and good communication. Questions about our Cancellation and No Show fees may be directed to the Practice Manager.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ _____

Patient Name (PLEASE PRINT) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

KANSAS CITY **SKIN & CANCER** CENTER LLC

PATIENT INFORMATION

PATIENT NAME: _____
(PLEASE PRINT)

DATE OF BIRTH: _____

How did you hear about us? (Please circle one.)

Referred by a doctor. Doctor's name: _____

Friend/family: _____

Internet

Self

Other: _____

Preferred pharmacy

Name: _____

Address: _____

_____

Phone: _____

KANSAS CITY **SKIN & CANCER** CENTER LLC

HISTORY AND INTAKE FORM: A

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
Seizures
Stroke
Valve Replacement

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
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Other

Other: _____

KANSAS CITY **SKIN & CANCER** CENTER LLC

HISTORY AND INTAKE FORM: B

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

Other: _____

Do you wear sunscreen regularly? 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 - without dose.)

_____

_____

_____

_____

_____

Allergies: (Please list all allergies.)

_____

_____

_____

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 ore than one partner
- Same sex partner

Illicit drug use:

- Drug use
- IV drug use

Alcohol use:

- None
- Less than 1 drink daily
- 1-2 drinks per day
- 3 or more drinks per day

Safety:

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

Other: _____

_____

_____

_____

_____

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Review of Systems:
Are you currently experiencing any of the following? Please circle "YES" or "NO."

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

Alerts:
Do you have any of the following? Please circle "YES" or "NO."

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