HEIGHTS DERMATOLOGY
& AESTHETICS

Retna Billano, M.D., F.A.A.D.

The following insurance and medical history forms are required to be regularly updated by the patient. We may be unable to file insurance payments or write prescriptions without complete and accurate information.

Please fill out this form completely and legibly. Leave nothing blank. If something does not apply, write "N/A" on the line.

Thank You!

4325 Dolly Ridge Road
Vestavia, AL 35243
205.591.2169

Fax: 205.591.0815
www.heightsdermatologyandaesthetics.com

HEIGHTS DERMATOLOGY
& AESTHETICS
4325 Dolly Ridge Road, Birmingham, AL 35243 (205)591-2169

PATIENT INFORMATION ***(Please Print)*** **TODAY'S DATE**___/____/____

Name_____Date of Birth____/____/____
Last First MI

Mailing Address_____
City State Zip Code

Home Phone_____Cell Phone_____Work Phone_____

SS#_____Sex_____Age_____Marital Status (Please Circle) S M D W

Employer_____Occupation_____
Email Address_____
Pharmacy Name & Number _____

Spouse/Parent's Name_____Date of Birth_____/_____/_____

SS#_____Employer_____Occupation_____

Home Phone_____Cell Phone_____Work Phone_____

In Case of Emergency, who should be notified?_____Phone_____

INSURANCE INFORMATION ***(Please present insurance card at time of check in)***

Primary **Insurance Name**_____	Secondary **Insurance Name**_____
Claim Address_____	**Claim Address**_____
Subscriber Name_____	**Subscriber Name**_____
Contract or ID #_____	**Contract or ID #**_____
Group #_____	**Group #**_____
Insured's Date of Birth_____/_____/_____	**Insured's Date of Birth**_____/_____/_____
Insured's SS#_____	**Insured's SS#**_____
Relationship of patient to insured_____	**Relationship of patient to insured**_____

Referred By_____ **Primary Care Physician**_____

I HAVE RECEIVED/BEEN OFFERED A COPY OF HEIGHTS DERMATOLOGY'S HIPAA PRIVACY POLICY.

I authorize the release of my medical information to my primary care, referring physician, consultants, labs, pathology, or chart auditors if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits directly to Heights Dermatology. I understand that payment for copays, coinsurances, deductibles or non-covered services is due at the time of service and that I am responsible for the charges incurred. I understand that failure to pay my copay at the time of service will result in a finance charge of $25.00 being added to my account. In the event that my account is turned over to collections, a 35% collection fee and any attorney fees will be added to my account. A fee of $38 will be assessed to any returned check. All surgical and cosmetic procedure cancellations within 48 hours and "NO SHOW" appointments will be charged a $100 missed appointment fee. All General Dermatology and Aesthetician services cancellations within 48 hours and "NO SHOW" appointments will be charged a $50 missed appointment fee. Two "NO SHOW" appointments may result in discharge from practice.

Patient or Responsible Party Signature_____**Date**_____/_____/_____

NON-COVERED ROUTINE SERVICES

AS YOUR HEALTH CARE PROVIDER, I WANT TO PROVIDE YOU WITH THE BEST POSSIBLE CARE. THERE MAY BE CERTAIN ROUTINE SERVICES THAT I FEEL ARE NECESSARY FOR THE MAINTENANCE OF YOUR GOOD HEALTH THAT ARE NOT COVERED BY YOUR HEALTH INSURANCE CONTRACT. THESE MAY INCLUDE BUT NOT BE LIMITED TO LAB PROCEDURES, PATHOLOGY SERVICES, INJECTIONS, OR INTRALESIONAL INJECTIONS.

By signing below, you accept the responsibility for any cost not covered by your insurance and agree to the financial policy of Heights Dermatology.

Patient Name (please print) _____

Signature _____**Date** ___/___/___

This section for Medicare Beneficiaries only

This office is required to keep your signature on file authorizing us to file claims so Medicare for you and to release information to that payor if they required it for proper consideration of a claim.

Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to Social Security Administration and Centers for Medicare and Medical Services (CMS) or its intermediaries, or carrier any information needed for this, or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare card Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file:

PLEASE PRESENT YOUR INSURANCE CARDS AND YOUR PHOTO ID TO THE RECEPTIONIST

AUTHORIZATION OF DISCLOSURE

DESIGNATED PERSONS AUTHORIZED TO RECEIVE MY PERSONAL HEALTH INFORMATION

Please list anyone it is okay for us to discuss your personal health information with:

NAME	RELATION	PHONE NUMBER

Patient Signature: _____

AUTHORIZED METHODS OF COMMUNICATION (CHECK ALL THAT APPLY)			
HOME #	WORK #	CELL #	WRITTEN CORESPONDENCE
___ Do not contact at this number	___ Do not contactat this Number	___ Do not contact at this number	__Mail/Delivery Service
__ Leave call back number only; do not leave message	_ Leave call back number only; do not leave message	_ Leave call back number only; do not leave message	__ Fax: _____
___ Okay to leave detailed message with person	___ Okay to leave detailed message with person	___ Okay to leave detailed message with person	___ Email @ residence Address:
___ Okay to leave detailed message on answering machine	____Oka to leave detailed message on personal voice mail	___ Okay to leave detailed message on voice mail	___ Email @ work Address:

PRIVACY POLICY WRITTEN ACKNOWLEDGMENT

I AM A PATIENT OF HEIGHTS DERMATOLOGY, DR. RETNA A. BILLANO
I HEREBY ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICE.

NAME (PLEASE PRINT) _____

SIGNATURE _____

DATE_____

OR

I AM A PARENT OR LEGAL GUARDIAN OF _____(PATIENT NAME)
I HEREBY ACKNOWLEDGE RECEIPT OF HEIGHTS DERMATOLOGY, DR. RETNA A. BILLANO NOTICE OF PRIVACY PRACTICES WITH RESPECT TO THE PATIENT.

NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

REASON FOR TODAY'S VISIT _____

Past Medical History: *Circle all that apply*

Anxiety	Depression	Hyperthyroidism
Arthritis	Diabetes	Hypothyroidism
Asthma	Renal disease	Leukemia
Atrial fibrillation	Gerd	Lung cancer
BPH (benign prostate hyperplasia)	Hearing loss	Lymphoma
Bone marrow transplant	hepatitis	Prostate cancer
Breast cancer	High blood pressure	Radiation treatment
Colon cancer	HIV/aids	Seizures
COPD	High cholesterol	Stroke
Coronary artery disease	Mitral Valve prolapse	Other: _____

Flu shot this season?	Yes	No
Pneumonia Vaccine?	Yes	No
Shingles Vaccine?	Yes	No

Past Surgical History: Circle all that apply

Appendix Removed	Kidney Removed (Right, Left)	Spleen Removed
Bladder Removed	Kidney Transplant	Testicles Removed (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)	Liver: Hepatectomy	Hysterectomy: Fibroids
Breast Lumpectomy (Right, Left, Bilateral)	Liver: Transplant	Hysterectomy: Uterine Cancer
Breast Biopsy (Right, Left, Bilateral)	Liver: Shunt	Hysterectomy: Cervical Cancer
Colectomy: Colon Cancer Resection	Ovaries removed: Endometriosis	List ANY Surgeries you have had: _____
Colectomy: Diverticulitis	Ovaries Removed Cyst	
Colectomy: IBD	Ovaries Removed Ovarian Cancer	
Gallbladder Removed	Ovaries Removed: Tubal Ligation	
Mechanical Valve Replacement	Prostate Biopsy	
Heart Transplant	Prostate Cancer	
Coronary Artery Bypass	TURP (Prostate Removal)	
Joint Replacement, Knee (Right, Left)	Pancreas: Pancreatectomy	
Joint Replacement, Hip (Right, Left)	Rectum: APR (Abdominoperineal Resection)	
Kidney stone removal		
Kidney Biopsy (Nephrectomy)	Rectum: Low Anterior Resection	

PATIENT NAME: _____ DATE: _____

Skin Disease History: *Circle all that apply*

Acne	Hay Fever/Allergies	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Psoriasis
Blistering Sunburns	Melanoma	Squamous Cell Skin Cancer
Rosacea		

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)? _____

Current Medications, Vitamins, and Supplements:

Medication	Dosage	Frequency

List drug allergies and the reaction you have to each drug:

_____

_____

Are you a smoker? Yes No Smoked in the past? Yes No

Number of Packs per day_____ Total years smoking_____

Alcohol Use: ☐ NONE ☐ Less than 1/day ☐ 1-2/day ☐ 3 or more/day

PATIENT NAME: _____ DATE: _____

Review of Systems

Please place a check next to your symptoms

☐ Problems with bleeding	☐ Night sweats	☐ Joint Aches
☐ Problems with healing	☐ Unintentional weight loss	☐ Muscle weakness
☐ Problems with scarring	☐ Thyroid problems	☐ Neck stiffness
☐ Rash	☐ Sore Throat	☐ Headaches
☐ Immuno Suppression	☐ Blurry Vision	☐ Seizures
☐ Hay fever	☐ Abdominal Pain	☐ Cough
☐ Chest pain	☐ Bloody Stool	☐ Anxiety
☐ Fever or Chills	☐ Bloody Urine	☐ Depression

Pertinent Immediate Family Medical History

_____

_____

_____

_____

Alerts: (Please circle any of the following that may apply to you)

Allergy to Adhesive	Defibrillator
Allergy to Lidocaine	MRSA
Allergy to Topical Antibiotics	Pacemaker
Artificial Heart Valve	Require Antibiotics prior to a Surgical Procedure
Artificial Joint Replacement (in the past 2 yrs)	Rapid heart with Epinephrine
Blood Thinners	

PATIENT NAME: _____ DATE: _____

PATIENTS 65 OR OVER ANSWER THE FOLLOWING QUESTIONS BELOW:

ADVANCE CARE PLANNING

Do you have a healthcare proxy in the event you are unable to make your own medical decisions?

Yes	No

If Yes:

_____

Designee's Name

_____

Designee's Phone Number

Do you have a living will?

Yes	No

If Yes, which statement best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

X _____ _____

Signature Date