McKitty Dermatology

Patient Information:

- Full Name: _____
- Date of Birth (MM/DD/YYYY): _____
- Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say
- Height: _____ Weight: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone: _____ ☐ Mobile ☐ Home
- Email: _____
- Pharmacy: _____
- Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Insurance Information:

- Primary Insurance Provider: _____
- Policy Number: _____
- Group Number: _____
- Policy Holder's Name: _____
- Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Emergency Contact:

- Name: _____
- Relationship: _____
- Phone: _____

Referring Provider (if applicable):

- Name/Practice: _____
- Phone/Fax: _____

Medical History:

1. **List any Skin Cancer History:**

Type of Skin Cancer (Basal Cell, Squamous Cell, or Melanoma)	Site	Year

2. **Do you have a family history of skin conditions or skin cancer?**
   ☐ No
   ☐ Yes – Type: _____ Family Member: _____

3. **List any chronic medical conditions:**

   _____

   _____

   _____

4. **Current Medications (including over-the-counter and supplements):**

   _____

   _____

   _____

5. **Are you allergic to any medications?**
   ☐ No
   ☐ Yes – Please list: _____

Social History:

- Do you smoke? ☐ No ☐ Yes – How much/how often: _____
- Do you drink alcohol? ☐ No ☐ Yes – How much/how often: _____
- Occupation: _____
- Do you spend a lot of time outdoors? ☐ No ☐ Yes

Patient Financial Policy:

1. **Insurance:** We will bill your insurance as a courtesy, but you are responsible for knowing your coverage and paying any balances not covered.
2. **Payment at Time of Service:** Co-pays, deductibles, and non-covered services are due at the time of your appointment.
3. **Self-Pay:** Full payment is required at the time of service for uninsured patients or services not covered by insurance.
4. **Cosmetic Procedures:** These are not covered by insurance and must be paid in full at the time of service.
5. **No-Shows & Late Cancellations:** A $75 fee may be charged for missed or late-canceled appointments without 24-hour notice.
6. **Returned Checks:** A $35 fee applies for checks returned due to insufficient funds.
7. **Delinquent Accounts:** Unpaid balances may be sent to collections.

We accept cash, credit/debit cards and HSA/FSA cards.

HIPAA Privacy and Restrictions:

The HIPAA privacy rules gives individuals the right to request a restriction on users and disclosures of their Protected Health Information (PHI). The individuals is also provided the right to request confidential communications or that a communication of PHI be made by alterative means, such as sending correspondence to the individual's office instead of their home.

Authorized Individuals (optional):
List anyone you authorize to receive your medical or billing information (e.g., spouse, parent, caregiver).

Name	Relationship	Phone

Communication Restrictions (Optional):

☐ Do **not** leave voicemail messages regarding medical information
☐ Do **not** communicate via email
☐ Other restrictions/preferences: _____

Consent and Acknowledgement:

By signing below, I acknowledge that I have read, understand, and agree to the policies stated above, including the Patient Financial Policy and HIPAA Privacy and Restrictions.

Patient Name (Print): _____

Patient/Guardian Signature: _____

Date: _____