INTEGRATED DERMATOLOGY

Enfield · Simsbury

Please confirm that we are contracted with your insurance before coming in. If we are not contracted you will be considered self-pay. Calling the number on the back of your insurance card is the easiest way to do this.

Be aware that some insurance companies require an insurance referral from your primary care physician to visit a specialist office. Please consult your benefits before your appointment. If one is required, please call your primary care and have them put one in through the insurance company portal. This is NOT a Dr. to Dr. referral; it goes directly to your insurance company. Provide them with the date of your appointment and the provider you will be seeing. Some insurances require all referrals to be under our supervising physician: Dr, Meagen McCusker

We will require the following information on or before your appointment date:

- Insurance company referral number with the number of visits allowed
- A start and end date of the insurance referral

If you require a referral to see a specialist and do not have one, you may be required to pay at the time of your visit. An example of some other services that may require payment at your visit because they are not covered by insurance are co-payments, co-insurance, cosmetic procedures, skin tag removals and deductibles. All payments can be made by cash or credit/debit card. WE DO NOT ACCEPT CHECKS

Failure to pay a balance due in a timely fashion may result in your inability to receive services from *Integrated Dermatology of Enfield/Simsbury* until the account is paid or payment arrangements have been made.

Your signature below signifies that you understand our referral and financial policy and your responsibility regarding charges incurred at *Integrated Dermatology of Enfield/Simsbury*.

I have read this policy and agree to the terms: (parent or guardian signature if minor)

Signature: _____ Date___/___/___

I have read and have received a copy of Integrated Dermatology of Enfield/Simsbury's notice of privacy practices form (Please ask for a copy if you would like one)

Signature: _____ Date___/___/___

Name: _____ Date of Birth: _____ Today's Date: _____

Medications: _____

_____

_____

_____

Allergies:

☐ Food/Environmental: _____

☐ Medication/Drug (Please include the reaction, if known):

_____

_____

Social History

☐ Tobacco: Type/Amount_____ ☐ Alcohol: Amount_____

☐ Tanning Bed Use: Frequency_____

Personal Medical History

☐ Anxiety	☐ Anemia	☐ Asthma	☐ Arthritis
☐ Bleeding Disorder	☐ Celiac Disease	☐ Chronic Bronchitis	☐ Colitis
☐ Congenital Disorder	☐ COPD	☐ Crohn's	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Emphysema	☐ GERD
☐ Headaches/Migraines	☐ Hearing Impaired	☐ Heart Murmur	☐ Hepatitis
☐ High blood pressure	☐ HIV (AIDS)	☐ High Cholesterol	☐ History of fainting
☐ IBS	☐ Immunosuppressed	☐ Kidney Disease	☐ Muscle Weakness
☐ Seasonal allergies	☐ Sinus Problems	☐ Tuberculosis	☐ Thyroid Disease
☐ Vision impaired	☐ Other: _____		☐ None

Events:

☐ History of blood clots: Year_____ ☐ History of Heart Attack: Year_____

☐ History of Stroke: Year_____ ☐ History of Cancer: Type_____

Female Specific:

☐ Family planning: pregnant / plan to conceive / breast feeding

☐ Gynecology Disorders ☐ Irregular Period

Surgical History:

☐ Joint replacement ☐ Cardiac Surgery ☐ Cancer Surgery ☐ Pacemaker Placement

☐ Organ Transplant/Donor ☐ Other_____

Personal Dermatology History

☐ Melanoma	☐ Non-Melanoma Skin Cancer	☐ Atypical Moles	☐ Psoriasis
☐ Hair-loss	☐ Eczema	☐ Chronic Hives	☐ Other_____

Family History

☐ Melanoma	☐ Inflammatory Bowel Disease	☐ Psoriasis	☐ Acne
☐ Cancer	☐ Hair loss	☐ Other_____	

Signature: _____

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(Please fill out to the FULLEST and print)

NAME: _____ DOB: ___/___/_____ SEX: M___F___
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS: _____

_____
(CITY) (STATE) (ZIP CODE)

SSN (this is for billing): _____-____-_____ EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

HOME #_____ CELL #_____ WORK #_____
☐ Detailed message allowed ☐ Detailed message allowed ☐ Detailed message allowed

Pharmacy Name: _____ Pharmacy Location: _____

PRIMARY CARE PHYSICIAN:

NAME: _____LOCATION: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PRIMARY INSURANCE: _____

ID #_____
POLICY HOLDER (if not self): _____
POLICY HOLDER'S DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE: _____

ID #_____ GROUP #_____

POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH _____

Ethnicity:
☐ Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian/Pacific Islander

Language:
☐ English ☐ Spanish ☐ French ☐ Russian ☐ Polish ☐ Other_____

Emergency contact: _____ Phone#_____ Relationship: _____
HIPAA (ok to discuss medical information with) contact: _____ Phone# _____