

# GRIESHABER DERMATOLOGY

EMILY GRIESHABER MD  
KRISTEN BICE MD

ROBERT GRIESHABER MD  
ALAN CRAWFORD MPAS, PA-C

## PATIENT INFORMATION (PLEASE PRINT CLEARLY)

PHARMACY/LOCATION \_\_\_\_\_ Date: \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

PREFERRED PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ GENDER \_\_\_\_\_

OCCUPATION \_\_\_\_\_ PRIMARY CARE PHYSICIAN \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

WHO MAY WE CONTACT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BEST CONTACT NUMBER \_\_\_\_\_

### EMAIL/SMS PROMOTIONS:

WOULD YOU LIKE TO RECEIVE EMAILS/SMS REGARDING SPECIAL EVENTS? YES/NO

WOULD YOU LIKE TO BE CONTACTED BY OUR ESTHETICIAN FOR A SKIN CONSULTATION?  
YES/NO

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

## PROTECTED HEALTH INFORMATION

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION (EX: BIOPSY/LAB RESULTS)

CONTACT NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

CONTACT NUMBER \_\_\_\_\_

DO YOU HAVE A POWER OF ATTORNEY? YES/NO IF YES, WHO \_\_\_\_\_

## CONSENT TO TREAT

I authorize and request that insurance benefits be paid directly to Grieshaber Dermatology should we elect to bill my insurance company.

I understand that I am financially responsible for any balance whether covered by insurance.

I authorize the release of my Personal Health Information to the referring physician, my insurance company, and laboratories, if applicable, for the purpose of treatment, payment, clinical management, and administrative duties.

I have been given the opportunity to review and/or receive a copy of Grieshaber Dermatology's Notice of Privacy Practices.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DOB \_\_\_\_\_

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## PAST MEDICAL HISTORY

PLEASE CHECK ALL THAT MAY APPLY TO YOU

- |   |  |
|---|--|
| <input type="checkbox"/> ANXIETY                  | <input type="checkbox"/> HYPOTHYROIDISM            |
| <input type="checkbox"/> ATRIAL FIBRILLATION      | <input type="checkbox"/> IMMUNOSUPPRESSIVE THERAPY |
| <input type="checkbox"/> STROKE                   | <input type="checkbox"/> DISEASE OF LIVER          |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> LEUKEMIA                  |
| <input type="checkbox"/> CORONARY ARTERY DISEASE  | <input type="checkbox"/> CANCER OF LUNG            |
| <input type="checkbox"/> DEPRESSION               | <input type="checkbox"/> CANCER OF BREAST          |
| <input type="checkbox"/> DIABETES                 | <input type="checkbox"/> CANCER OF COLON           |
| <input type="checkbox"/> END STAGE RENAL DISEASE  | <input type="checkbox"/> RADIATION                 |
| <input type="checkbox"/> HIGH BLOOD PRESSURE      | <input type="checkbox"/> BONE MARROW TRANSPLANT    |
| <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> HIGH CHOLESTEROL          |
| <input type="checkbox"/> HYPERTHYROIDISM          |  |
| <input type="checkbox"/> OTHER MEDICAL CONDITIONS |  |

DO YOU HAVE ANY CONDITIONS OR TAKE MEDICATION THAT COMPROMISE YOUR IMMUNE SYSTEM? \_\_\_\_\_

## SKIN DISEASE HISTORY

BASAL CELL SKIN CANCER     SQUAMOUS CELL SKIN CANCER     TANNING BED USE  
 MELANOMA

DO YOU HAVE FAMILY HISTORY OF MELANOMA? YES/ NO  
IF YES, WHICH RELATIVE? \_\_\_\_\_

<p>LIST OF CURRENT MEDICATIONS (Please attach list if you have it)</p>	<p>ARE YOU ALLERGIC TO ANY MEDICATION?</p>
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## SOCIAL HISTORY/MEDICAL ALERTS

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> CURRENTLY SMOKES                 | <input type="checkbox"/> HAS SMOKED IN PAST | <input type="checkbox"/> NEVER SMOKED           |
| <input type="checkbox"/> PACEMAKER                        | <input type="checkbox"/> DEFIBRILLATOR      | <input type="checkbox"/> ARTIFICIAL HEART VALVE |
| <input type="checkbox"/> ALLERGY TO ADHESIVE              | <input type="checkbox"/> BLOOD THINNERS     | <input type="checkbox"/> ALLERGY TO LIDOCAINE   |
| <input type="checkbox"/> PREMEDICATION PRIOR TO PROCEDURE |   |   |
| <input type="checkbox"/> PREGNANCY OR PLANNING PREGNANCY  |   |   |

IN THE PAST 12 MONTHS, HAVE YOU HAD ANY CONCERNS ABOUT FOOD, HOUSING, TRANSPORTATION OR SAFETY? YES/NO/DECLINE TO ANSWER

## Credit Card on File Agreement

Grieshaber Dermatology has implemented a new credit card policy. Much like many other businesses such as a hotel or car rental agency, attorneys, etc. we now have a similar policy where we ask for a credit card to secure your appointment and which may be used later to pay any balance that may be due on your bill.

As you know, there are charges for each of the medical care services that we will provide to you. The co-payments, deductibles and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals, but please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits. Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided to you.

Your health benefits, including your responsibility for co-payments, deductibles and co-insurance is a decision made by your employer, not this office or your health plan.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

## Communications Consent

Would you like to receive email or text communications from our office regarding special events and promotions?

I would like to receive messages about events and promotions.: No