

CENTRAL ILLINOIS DERMATOLOGY, S.C.

Patient Information

Name: _____ **Gender** _____
 First Middle Initial Last M or F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **SS#:** _____

Birthdate: _____ **Age:** _____ **Marital Status:** M S D W
 (Month/Day/Year)

Employer: _____ **Occupation:** _____

Preferred Hospital: UnityPoint or OSF **Email:** _____

Emergency Contact: _____ **Daytime Ph #** _____

Relationship: _____

Referring Physician: _____ **Ph #** _____

Primary Care Physician: _____ **Ph #** _____

*****If under 18, or still under parents' insurance, please list parents' names and phones*****

Mother: _____ **Daytime Ph #** _____

Father: _____ **Daytime Ph #** _____

INSURANCE

Primary: _____ **Insured:** _____

Insured's Birthday: _____ **Relationship to Insured:** _____

Policy Number: _____ **Group #** _____

Secondary: _____ **Insured:** _____

Insured's Birthday: _____ **Relationship to Insured:** _____

Policy Number: _____ **Group #** _____

I hereby authorize Central Illinois Dermatology, S.C. to release pertinent information via phone, print or fax for my medical treatment and/or billing purposes. My signature further indicates my consent for treatment and care by the physicians and medical staff at Central Illinois Dermatology, S.C.

Patient/Parent/Legal guardian or (POA) Power of Attorney

Date

CENTRAL ILLINOIS DERMATOLOGY, S.C.

Patient Medical Information

Patient Name: _____

Allergies to Medication (oral and topical): _____

Medications Presently Using (oral and topical): _____

If medications are prescribed by our physicians, do you prefer: Brand _____ Generic _____

	Yes	No		Yes	No
Artificial Joints	_____	_____	Heart Disease	_____	_____
Kidney Disease	_____	_____	Diabetes	_____	_____
Stomach Disease	_____	_____	Liver Disease	_____	_____
Lung Disease	_____	_____	Mental Illness	_____	_____
Epilepsy	_____	_____	Excessive Bleeding	_____	_____
High Blood Pressure	_____	_____	Valvular Heart Disease	_____	_____
Unusual Scarring	_____	_____	Pregnant (currently)	_____	_____
Bacterial Endocarditis	_____	_____	Tubal ligation or		
Cancer	_____	_____	Hysterectomy	_____	_____
Type _____			Do you take aspirin		
Do you take birth			or Advil daily?	_____	_____
Control pills	_____	_____	Do you have a		
			pacemaker?	_____	_____

Other _____

<p align="center">❖ Do you give our office permission to discuss your medical information with family members?</p> <p align="center">_____ YES _____ NO</p> <p align="center">If yes, please provide their name, phone number, and relationship below.</p>		
_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship
Patients' signature: _____		Date: _____

Payment Policy

Payment is expected at time of service, unless prior arrangements have been made. Insurance companies vary in terms of reimbursement. We will be happy to give you an itemized statement which will assist you in billing your insurance carrier. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement. You are responsible for payment of all charges on your account within the limits of our credit policy.

I have read the above information concerning insurance and understand that I am responsible for payment in full of all charges incurred during my treatment.

Signature: _____ **Date:** _____

Patient (Parent or legal guardian)

**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)**

With my consent, Central Illinois Dermatology, S.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

Please refer to Central Illinois Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand the Notice I received explains my rights and contains information to assist me if I should have questions or a complaint. Central Illinois Dermatology, S.C. reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Central Illinois Dermatology's privacy officer at 5401 N. Knoxville, Ste. #115, Peoria, IL 61614.

With my consent, Central Illinois Dermatology may call numbers listed on my patient information sheet for home, work, cellular phone or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results. By signing below, I agree to any fees or charges that I may incur for incoming calls, and/or outgoing calls to or from any such number given, without reimbursement from Central Illinois Dermatology.

With my consent, Central Illinois Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder notes and patient statements.

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Central Illinois Dermatology's use and disclosure of my PHI to carry out TPO.

By signing this form I, or the person signing for me, acknowledge receiving a 'Notice of Privacy Practices' from Central Illinois Dermatology. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Central Illinois Dermatology may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patients' Name (Printed Please)

Date

112 (5/13) CMFI



How would you like to receive your **appointment reminders** (Please print clearly)

Please CHOOSE 1 option:

- (P) Home phone – Phone call Phone # _____
- (C) Cell phone – Phone call Cell Phone # _____
- (T) Cell phone – Text Message Cell Phone # _____
- (E) Email Address – Email Email Address _____
- (N) I do not wish to receive appointment reminders

Name _____ Date _____

Date of Birth _____ Zip code _____