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 Hysterectomy	_____	_____
Cancer	_____	_____	Do you take aspirin or Advil daily?	_____	_____
Type ______________________			Do you have a pacemaker?	_____	_____
Do you take birth Control pills	_____	_____			

Other______________________________

❖ **Do you give our office permission to discuss your medical information with family members?**

____YES   _____NO

If yes, please provide their name, phone number, and relationship below.

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/messages, and/or outgoing calls/messages to or from any such number given, without reimbursement from Central Illinois Dermatology.

By signing below, I am giving my consent that Central Illinois Dermatology may mail, securely email or fax to me, at my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder notes, patient statements, and any part of my medical record.

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

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 ____________________