CENTRAL ILLINOIS DERMATOLOGY, S.C.
Patient Information

Name:_____ **Birth Gender**____
First Middle Initial Last M / 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:** _____

Email: _____ **Reminder Preference: Text / Call Cell / Call Home**
Circle ONE

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.

Signature: _____ Date: _____
Patient/Parent/Legal guardian or (POA) Power of Attorney

CENTRAL ILLINOIS DERMATOLOGY, S. C.
Patient Medical Information

Patient Name: _____ **DOB**: _____

ALLERGIES: _____

MEDICATIONS Presently Using (oral and topical):_____

_____

_____

MEDICAL HISTORY: Select any of the following medical conditions that apply to you

Artificial Joints		Heart Disease		Organ Transplant	
Date:_____		Valvular Heart Disease		Organ:_____	
HIV		Liver Disease		Pacemaker	
Hepatitis		Neurological / Brain Disease		Family History of Melanoma	
Lung Disease		Mental Illness		Thyroid Disease	
Epilepsy		Excessive Bleeding		Take Aspirin or Advil daily	
High Blood Pressure		Diabetes		Cancer	
Unusual Scarring		Pregnant (currently)		Type: _____	
Bacterial Endocarditis		Tubal ligation or Hysterectomy		Other:	
Kidney Disease		Take Birth Control Pills		_____	

- **Do you give our office permission to discuss your medical information with any other individual? ____YES _____NO**

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

_____ _____ _____
Name Phone Relationship

_____ _____ _____
Name Phone Relationship

PAYMENT POLICY

We will file insurance claims on your behalf with insurances we are contracted with. Because your insurance is a contract between you and your health insurance, it is your responsibility to obtain any necessary authorization and/or referrals (if required). Knowing your policy benefits and limitations is your responsibility. If you have any questions regarding coverage, copayments or deductibles, we strongly suggest you contact your insurance company before any services are rendered. Payment of copays, self-pay fees, and non-contracted insurance fees (including Medicare) are expected at time of service, unless prior arrangements have been made. If you are billing a non-contracted insurance, we can provide 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. It is our policy to make all reasonable attempts to collect outstanding balances should they accrue, including payment arrangements. All payment plans must be negotiated and approved by the billing staff; we ask that you call as soon as possible to initiate a monthly payment arrangement, if needed. Statements are sent out monthly. If your account is over 90 days past due without attempt at payments to be made, your account will be placed in collection hold and payment in full will be due before any further appointments can be made. I have read the above information and understand Central Illinois Dermatology's Payment Policy.

Signature: _____ Date: _____
Patient/Parent/Legal guardian or (POA) Power of Attorney

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 (Print Please)

_____ _____

DOB Date