HULL DERMATOLOGY & AESTHETICS

599 Horsebarn Rd. | Rogers, AR 72758 | hullderm.com
Telephone: 479.254.9662 | Fax: 479.254.9652

Patient Information Sheet This form must be completed for all patients

Name: _____ **Date:** _____
Last First MI

Referring Provider: _____

How did you hear about us? _____

Reason for Visit: _____ **Primary Care Physician:** _____

Date of Birth: _____ **Gender:** M___ F___ **Social Security Number:** _____

Mailing Address: _____
City State Zip

Primary Phone: _____ **Secondary Phone:** _____ **Work Phone:** _____ **Ext:** ____

Ok to Leave Message: Home ___ Cell ___ Work ___ **Preferred Pharmacy:** _____

Employer Name: _____ **Address:** _____
City State Zip

Email Address: _____ **Would you like to view your information online?** Yes ___ No ___
Ex: Request appointment, request refills on prescriptions, view lab results, and ask questions.

Ethnicity: Hispanic or Latino___ Not Hispanic or Latino ___ Refuse to report___

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ Preferred Language: _____

Race: Asian ___ Native Hawaiian ___ African American ___ White ___ Hispanic ___ Other ___ Refuse to report ___

Responsible Party Name: _____
Last First MI

Date of Birth: _____ **Social Security Number:** _____

Address: _____
City State Zip

Emergency Contact Name: _____ **Phone Number:** _____

Relationship: _____ **Address:** _____

If Policy Holder is different than the patient:

Primary Insurance: _____ **Policy Holder:** _____

Social Security Number: _____ **Date of Birth:** _____

Policy Holder's Employer: _____ **Employer Phone Number:** _____

Secondary Insurance: _____ **Policy Holder:** _____

Social Security Number: _____ **Date of Birth:** _____

Policy Holder's Employer: _____ **Employer Phone Number:** _____

Benefits Assignment: I hereby authorize the assignment of benefits (payments) directly to Hull Dermatology, P. A. for all my insurance claims related to services received. I agree to pay any and all charges that exceed or are not covered by my insurance. I understand that Co-pays, deductibles and non-covered services are due at time of service.

Signature of Responsible Party: _____ **Date:** _____

Record Release: I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ **Date:** _____

Hull Dermatology, P.A. may release financial/medical information to:

Name(s): _____

Phone Number(s): _____

If left blank, we will only be able to inform you (the patient) of your financial/medical information except in the case of minors.

Medical History Questionnaire

Are you allergic to any medications? Yes ___ No ___ **Are you Pregnant?** Yes ___ No ___

If yes, list meds and reactions below: _____

Have you ever had a reaction to Novocaine, Lidocaine, bandages, or topical antibiotics (Neosporin)? Yes ___ No ___

If yes, please list: _____

Please list current medications you are taking (including prescriptions, over the counter meds, vitamins, herbal supplements):

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

Please list below any drug allergies:

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

Have you had surgery or have been hospitalized in the past? If yes, please list: _____

_____

Have you had skin cancer surgery in the past? Yes ___ No ___

Please let any chronic medical conditions for which you are currently being treated: _____

_____

General Dermatology Please check all that apply:

- ☐ Melanoma
- ☐ Atypical moles
- ☐ Dysplastic moles
- ☐ Squamous Cell Carcinoma
- ☐ Basal Cell Carcinoma
- ☐ Actinic Keratosis
- ☐ Skin Cancer (type unknown)
- ☐ Chronic Skin Disease
- ☐ History of keloid / scarring
- ☐ Bleeding easily
- ☐ HIV

Social History Please check all that apply

- ☐ Had more than one severe sunburn
- ☐ Had significant occupational sun exposure
- ☐ Use or have used a tanning bed
- ☐ Use sunscreen
- ☐ Been exposed to HEP A, B, C, D
- ☐ Been exposed to HIV
- ☐ Use or have used alcohol
- ☐ Use or have used tobacco
- ☐ Used drugs (including marijuana)
- ☐ Traveled outside the US in the last three months

What is your occupation? _____

What is your hobby? _____

Have you ever had a history of? Please check all that apply:

- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Morning Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Heart attack
- ☐ Irregular Heartbeat
- ☐ Phlebitis
  - ☐ Inflammation of vein
  - ☐ Blood Clots
- ☐ Pacemaker
- ☐ Fainting
- ☐ Diabetes
  - ☐ Excessive Thirst/Hunger
  - ☐ Amputation
- ☐ Thyroid Disease
- ☐ Kidney Disease/Failure
  - ☐ Dialysis
- ☐ Urinary Tract Infection
- ☐ Stomach absorptive disorder
- ☐ Nausea, vomiting, diarrhea when taking antibiotics
- ☐ Yeast infection when taking antibiotics
- ☐ Arthritis/Joint Deformity
  - ☐ Arthralgia
  - ☐ Limited Motion
  - ☐ Artificial Joint
- ☐ Convulsions, Epilepsy, Seizures

Family History of Skin Cancer Please check all that apply:

Mother	☐ None	☐ Melanoma	☐ Atypical Moles	☐ SCC	☐ BCC	☐ Actinic Keratosis	☐ Unknown Skin Cancer
Father	☐ None	☐ Melanoma	☐ Atypical Moles	☐ SCC	☐ BCC	☐ Actinic Keratosis	☐ Unknown Skin Cancer
Sister(s)	☐ None	☐ Melanoma	☐ Atypical Moles	☐ SCC	☐ BCC	☐ Actinic Keratosis	☐ Unknown Skin Cancer
Brother(s)	☐ None	☐ Melanoma	☐ Atypical Moles	☐ SCC	☐ BCC	☐ Actinic Keratosis	☐ Unknown Skin Cancer
Daughter(s)	☐ None	☐ Melanoma	☐ Atypical Moles	☐ SCC	☐ BCC	☐ Actinic Keratosis	☐ Unknown Skin Cancer
Son(s)	☐ None	☐ Melanoma	☐ Atypical Moles	☐ SCC	☐ BCC	☐ Actinic Keratosis	☐ Unknown Skin Cancer
Other	☐ None	☐ Melanoma	☐ Atypical Moles	☐ SCC	☐ BCC	☐ Actinic Keratosis	☐ Unknown Skin Cancer

Comprehensive Review of Systems Please check all that apply:

Allergy
- ☐ Runny nose
- ☐ Scratchy throat
- ☐ Itchy eyes
- ☐ Sneezing
- ☐ Ear fullness
- ☐ Stuffy nose
- ☐ Cough

Constitutional
- ☐ Weight change
- ☐ Loss of appetite
- ☐ Fever
- ☐ Weakness
- ☐ Night sweats
- ☐ Breast feeding (if applicable)

Dermatology
- ☐ Suspicious lesions
- ☐ Suspicious moles
- ☐ Rash
- ☐ Itching
- ☐ Dry or sensitive skin
- ☐ Photosensitivity
- ☐ Hives
- ☐ Hair loss
- ☐ Lumps
- ☐ Jaundice

Gastroenterology
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Constipation
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Change in bowel habits

Psychology
- ☐ Depression
- ☐ High stress
- ☐ Mood swings
- ☐ Suicidal ideation
- ☐ Obsessive-compulsive tendencies

ENT
- ☐ Nose bleeds
- ☐ Change in voice
- ☐ Sore throat
- ☐ Difficulty swallowing

Respiratory
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Cough
- ☐ Wheezing
- ☐ Congestion

Neurology
- ☐ Headache
- ☐ Tingling numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Focal weakness

Cardiology
- ☐ Palpitations
- ☐ Chest pains
- ☐ High blood Pressure

Hematology
- ☐ Easy bruising
- ☐ Swollen glands
- ☐ Fatigue

Genitourinary Female
- ☐ Premenstrual Syndrome
- ☐ Infertility
- ☐ Dysmenorrheal
- ☐ Frequent yeast infections
- ☐ Vaginal itching
- ☐ Intermenstrual bleeding
- ☐ Pelvic pain
- ☐ Sexual activity
- ☐ Irregular periods
- ☐ Abnormal vaginal discharge

Opthamology
- ☐ Eye irritation
- ☐ Drainage from eyes
- ☐ Blurring of Vision

Endocrinology
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive urination
- ☐ Cold intolerance
- ☐ Heat intolerance

Urology
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Urinary incontinence

Musculoskeletal
- ☐ Joint stiffness
- ☐ Leg cramps
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle aches

Hull Aesthetics Policies Please read and check the boxes acknowledging you understand each policy:

Cancellation and Missed Appointment Policy: At Hull Dermatology & Aesthetics, we are dedicated to our patient care and service. We try to contact all of our patients at least 24 hours before their scheduled appointment to remind them of the date and time. In the event that you are unable to keep a scheduled appointment, we request that you inform us by telephone at least 24 hours in advance. This allows us time to contact patients on our waiting list and offer the time slot to them. Our providers' time is valuable as we always have an extensive waiting list of both new and established patients. Patients who do not notify us at least 24 hours before their scheduled appointment time will be considered a "no show" and will be assessed a fee. The fee breakdown is below:

☐ I understand that missing an appointment scheduled for an hour or less will incur a $50 fee. I will not be able to schedule a new appointment or receive any other services until this fee is paid in full.

☐ I understand that missing an appointment scheduled for more than one hour will incur a $100 fee per hour. I will not be able to schedule a new appointment or receive any other services until this fee is paid in full.

☐ By signing and dating below, I acknowledge that I have read and understand the above document.

Signature of Responsible Party: _____ **Date:** _____

☐ **Late Arrivals:** To ensure the quality of your treatment, arriving late to a scheduled appointment may result in your treatment being shortened, the technician being changed, or your appointment being rescheduled for a later date.
☐ **Price Changes:** Though we will make every effort to keep you Informed of price changes, our fees and services are evaluated continuously and are subject to change. Please note that if you find a better price advertised locally, we will be happy to match that pricing when presented with the advertisement.
☐ **Prepaid Services:** All prepaid services should be used within one year of purchase. There are no refunds on prepaid services. Monies can be used for other services or product if done within one year of purchase.
☐ **Auction and Giveaways:** Any product or service won must be used within one year unless otherwise specified by Hull Aesthetics. These are non-refundable and cannot be traded for other services or products.
☐ **Products and Services:** All sales are final. Only defective products will be returned. Please read all consents closely for side effects; every patient is different and can respond differently to treatment. No refunds are given on services.
☐ **Package Purchases:** Prepaid packages are tracked by treatment cards. We will keep these cards on file.
☐ I have read and understand the Hull Aesthetics policies.

Signature of Responsible Party: _____ **Date:** _____

Interpreter Service

Hull Dermatology, PA has arranged for language assistance services free of charge. Call 479.254.9662 TTY 479.254.9662

ENGLISH
If you speak English, language assistance services, free of charge, are available to you.

SPANISH
Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno

VIETNAMESE
Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị, nếu quý vị nói tiếng Việt.

MARSHALLESE
Elaññe kwojelā Kajin Majōl, kwomaroñ bōk jibañ ilo Kajin Majōl, ejjelok wōneen.

CHINESE
如果您讲汉语普通话，则可以免费向您提供语言协助服务。

LAOTIAN
ຖ້າທ່ານເວົ້າ ພາສາລາວ ແມ່ນມີບໍລິການຊ່ວຍເຫຼືອພາສາຟຣີໃຫ້ແກ່ທ່ານ.

TAGALOG
Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo sa lengguahe na walang baya

ARABIC
كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية مجانا.

GERMAN
Wenn Sie deutsch sprechen, stehen Ihnen kostenlos Sprachhilfen zur Verfügung.

FRENCH
Si votre langue est le français, des services d'assistance linguistiques sont mis gratuitement à votre dispositior

HMONG
Yog koj hais lus Hmoob, peb muaj neeg txhais lus, pub dawb rau koj.

KOREAN
모국어가 한국어일 경우 무료 언어지원 서비스가 제공됩니다.

PORTUGUESE
Se você fala português, está disponível atendimento gratuito com assistência ao idioma.

JAPANESE
日本語を話される場合には、無償の言語支援サービスがご利用いただけます。

HINDI
अगर आप हिन्दी बोलते हैं तो भाषा सहायता सेवा निःशुल्क उपलब्ध है।

GUJARATI
તમે ગુજરાતી બોલતા હો, તો વિના મૂલ્યે, ભાષા સહાય સેવાઓ તમને ઉપલબ્ધ છે.

Notice of Privacy Practices Revised September 8, 2011. This information is made available to all patients.
This notice describes how medical information about you may be used and disclosed and how you may have access to this information. Please review it carefully.
This notice applies to all of the records of your care generated by the practice, whether made by the practice or an associated facility.
This notice describes our practice's policies, which extend to:

- Any health care professional authorized to enter information in your chart (including physicians, Pas, RNs, etc.);
- All areas of practice (front desk, administration, billing and collection, etc.);
- All employees, staff and other personnel that work for or with our practice;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians and so on.

Hull Dermatology provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

By listing your Primary Care Physician (PCP), we are able to share and obtain information critical to your care. Please update us regularly if this information changes, so we may keep your PCP informed of your care.

Payment Policy:

1. **Insurance:** We participate in most insurance plans including Medicare. You are responsible for verifying participation in your specific plan network. Knowing and understanding your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding coverage. Additionally, if eligibility is not verifiable, payment will be due at the time of service.
2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.
3. **Non-covered Services:** Please be aware that some services you receive may be non-covered. Our office will try to inform you of these services prior to treatment. Ultimately, it is your responsibility to know your benefits and non-covered services will be the patient's responsibility.
4. **Claims Submission:** We will submit your claims and assist you in any way within reason to get your claims paid. Often your insurance will need you to supply information. It is your responsibility to comply with these requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays.
5. **Children of Divorced Parents:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved with out the inclusion of Hull Dermatology.
6. **Pathology/Lab Billing:** When a lesion is removed in office, it is the standard of care is to have a pathologist examine the specimen. These services are primarily performed by Dr. Hull but are billed on a separate date of service. Due to this your insurance may assess a separate co-payment. Lab and pathology that are referred out are billed by the lab companies; any questions in regards to those charges need to be directed to them.
7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if the balance remains unpaid it will be referred to a collection agency.

Our office is committed to providing the best treatment to our patients. Our charges are representative of the usual and customary charges for our area. We thank you for understanding our payment policy.

☐ I have read and understand the payment policy.

Signature of Responsible Party: _____ **Date:** _____