

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:

- | | | |
|--------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> History of keloid / scarring |
| <input type="checkbox"/> Atypical moles | <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Bleeding easily |
| <input type="checkbox"/> Dysplastic moles | <input type="checkbox"/> Skin Cancer (type unknown) | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Squamous Cell Carcinoma | <input type="checkbox"/> Chronic Skin Disease | |

Social History Please check all that apply

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

What is your occupation? _____

What is your hobby? _____

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

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

Family History of Skin Cancer Please check all that apply:

- | | | | | | | | |
|-------------|-------------------------------|-----------------------------------|-----------------------------------------|------------------------------|------------------------------|--------------------------------------------|----------------------------------------------|
| Mother | <input type="checkbox"/> None | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> SCC | <input type="checkbox"/> BCC | <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Unknown Skin Cancer |
| Father | <input type="checkbox"/> None | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> SCC | <input type="checkbox"/> BCC | <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Unknown Skin Cancer |
| Sister(s) | <input type="checkbox"/> None | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> SCC | <input type="checkbox"/> BCC | <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Unknown Skin Cancer |
| Brother(s) | <input type="checkbox"/> None | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> SCC | <input type="checkbox"/> BCC | <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Unknown Skin Cancer |
| Daughter(s) | <input type="checkbox"/> None | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> SCC | <input type="checkbox"/> BCC | <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Unknown Skin Cancer |
| Son(s) | <input type="checkbox"/> None | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> SCC | <input type="checkbox"/> BCC | <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Unknown Skin Cancer |
| Other | <input type="checkbox"/> None | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Atypical Moles | <input type="checkbox"/> SCC | <input type="checkbox"/> BCC | <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> 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

Ophthalmology

- 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

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 your 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.

Release of Photos

I authorize the use and disclosure of my initials, age, gender, photographic/video images, and/or testimonial for marketing purposes by Hull Dermatology and Aesthetics.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

I authorize the use of these images without compensation to me.

I understand that this information may be used for social media and advertising. I give my consent to the following platforms:

Hull Photo Results Book ___ Print Ads ___ Instagram ___ Facebook ___ Snapchat ___ YouTube ___ RealSelf ___ Hullderm.com website ___

I understand that all negative, prints, and/or digital reproductions shall be the property of Hull Dermatology and Aesthetics and will not be returned. I hereby authorize the editing, altering, copying, exhibiting, publishing, or distribution of this photo/video for purposes of publicizing Hull Dermatology & Aesthetics programs. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive.

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

Elañe kwojelā Kajin Majōl, kwomarōñ 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

ຖ້າທ່ານເວົ້າພາສາລາວ ແມ່ນມີບໍລິການຊ່ວຍເຫຼືອພາສາພຣ໌ໃຫ້ແກ່ທ່ານ.

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 مجاناً.

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 disposition

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.

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: _____

Cosmetic Interest Questionnaire

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply:

- | | | |
|---------------------------------------------------------|------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Skin care advice | <input type="checkbox"/> Blotchy skin | <input type="checkbox"/> Mole removal |
| <input type="checkbox"/> Skin care products | <input type="checkbox"/> Facial veins | <input type="checkbox"/> Neck wrinkles |
| <input type="checkbox"/> Facial injectables-fillers | <input type="checkbox"/> Facial redness | <input type="checkbox"/> Scar revision |
| <input type="checkbox"/> Facial fine lines and wrinkles | <input type="checkbox"/> Brown spots/age spots | <input type="checkbox"/> Abdominal area |
| <input type="checkbox"/> Thin lips | <input type="checkbox"/> Freckles | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Length of eyelashes | <input type="checkbox"/> Drooping brow | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Fullness of eyelashes | <input type="checkbox"/> Drooping eyelids | <input type="checkbox"/> Facial contouring |
| <input type="checkbox"/> Darkness of eyelashes | <input type="checkbox"/> Nose size or shape | <input type="checkbox"/> Body contouring |
| <input type="checkbox"/> Chemical peel | <input type="checkbox"/> Facial fullness or drooping | <input type="checkbox"/> Unwanted hair |

Please contact me about these services

Best phone number to reach you:

Please send me information on products and services (including special offers)

Email Address:
