

YARDLEY DERMATOLOGY ASSOCIATES

PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

New Patient Name Change Address Change Insurance Policy/Holder Change

PATIENT INFORMATION

Last Name: _____	First Name: _____	Middle Initial: ____
DOB: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address: _____	City/State: _____	Zip: _____
Phone #: _____	SS#: _____	
Employer/School: _____		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		

INSURANCE POLICY HOLDER INFORMATION

Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Legal Guardian		
<input type="checkbox"/> Other: _____		
Last Name: _____	First Name: _____	Middle Initial: ____
DOB: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address: _____	City/State: _____	Zip: _____
Phone #: _____	SS#: _____	
Employer: _____		
Secondary Insurance Policy: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Last Name: _____	First Name: _____	Middle Initial: ____
DOB: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone #: _____
Address: _____	City/State: _____	Zip: _____

PHARMACY INFORMATION

Pharmacy: _____	Phone #: _____
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YARDLEY DERMATOLOGY ASSOCIATES

PATIENT CONTACT FORM

I would like to receive my courtesy appointment reminder via: Home Phone Work Phone Cell Phone

Yardley Dermatology Associates has my permission to:

YES NO **Contact me at home #:** _____
 YES NO Leave a detailed voicemail message
 YES NO Leave a detailed message a household/family member
Household/Family member(s) name(s): _____

YES NO **Contact me by cell phone #:** _____
 YES NO **Contact me at work #:** _____
 YES NO Leave a detailed voicemail message
 YES NO Leave a detailed message with a staff member
Staff member(s) name(s): _____

YES NO **Contact me by e-mail**
E-mail: _____
 YES NO Leave appointment reminders via e-mail in addition to a phone reminder

YES NO **Discuss my medical history with anyone other than myself**
(In addition to those specified by law to carry out treatment, payment, and healthcare operations)
Name(s): _____

Emergency Contact

Name: _____
Phone #: _____

Primary Care Physician

Name: _____
Phone #: _____ Did your PCP refer you? YES NO

Signature of Patient or Legal Guardian

Date

Printed Name of Patient

YARDLEY DERMATOLOGY ASSOCIATES

PATIENT CONSENT FORM

Patient Name (print): _____ DOB: _____

Legal Guardian Name (print): _____

AUTHORIZATIONS

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to YARDLEY DERMATOLOGY ASSOCIATES. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patient and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa™, or Mastercard™. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered service, and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

Patient or Legal Guardian Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent YARDLEY DERMATOLOGY ASSOCIATES may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to YARDLEY DERMATOLOGY ASSOCIATES' 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. YARDLEY DERMATOLOGY ASSOCIATES 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 YARDLEY DERMATOLOGY ASSOCIATES Privacy Officer at 903 Floral Vale Blvd. Yardley, PA 19067. With my consent YARDLEY DERMATOLOGY ASSOCIATES may call my home 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 among others. With my consent YARDLEY DERMATOLOGY ASSOCIATES may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent YARDLEY DERMATOLOGY ASSOCIATES may e-mail my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that YARDLEY DERMATOLOGY ASSOCIATES restrict how it uses or discloses my PHI to carry out TPO. However, 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 YARDLEY DERMATOLOGY ASSOCIATES' use and disclosure of my PHI to carry out TPO. 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 YARDLEY DERMATOLOGY ASSOCIATES may decline to provide treatment to me.

Patient or Legal Guardian Signature: _____ Date: _____

MEDICARE HEALTH INSURANCE FORM

I request that payment of authorized Medicare benefits be made either to me or on my behalf to YARDLEY DERMATOLOGY ASSOCIATES for any services furnished to me by YARDLEY DERMATOLOGY ASSOCIATES. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

Patient or Legal Guardian Signature: _____ Date: _____

YARDLEY DERMATOLOGY ASSOCIATES

PATIENT PROGRESS FORM

Name: _____ Date: _____

Occupation: _____ Age: _____

Medication Allergies: _____

Present or Past Medical Problems: _____

Previous Surgical Procedures: _____

Medications & Supplements: _____

Personal History of Skin Cancer (type, location, & date): _____

Are you currently experiencing symptoms or problems related to:

- Asthma/allergies/hayfever Yes No
- Fever/weight loss Yes No
- Eyes ears/nose Yes No
- Heart Yes No
- Lungs Yes No
- Hormones Yes No
- Stomach/colon Yes No
- Urinary system Yes No
- Muscles/bones Yes No
- Neurological/seizures/headaches Yes No
- Emotional/mental illness Yes No

Do have a(n)/Have you had a(n)?

- Artificial joint Yes No
- Artificial heart valve Yes No
- Pacemaker Yes No
- Bleeding condition Yes No
- Hepatitis/HIV Yes No
- Heart valve infection Yes No
- Radiation/X-Ray treatment Yes No
- Family history of melanoma Yes No

Relationship: _____

Tobacco Use? Yes No Alcohol/Drug Use? Yes No Pregnant or planning soon? Yes No

Reason for today's visit (include location on the body, duration of problem, description of symptoms (painful, itching, bleeding, etc.), and treatments used in the past): _____

Yardley Dermatology Associates

**Richard G. Fried, M.D.,
Fern G. Fried, M.D
Jennifer R. Rajan, M.D.
Judith A. Cenci, M.D.**

**Carmen Campanelli, M.D.
Lauren Sternberg, M.D.
Jennifer LaRusso, D.O.
Amy Matorin, PA-C**

MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____

I hereby authorize the release of my medical records to Yardley Dermatology Associates:

Signature of Patient or Legal Guardian

Date

I am requesting medical records from:

Doctor, Hospital, Insurance Company, etc.

Address: _____

Phone: _____

Fax: _____

Included in these records:

Recent Biopsy or Bloodwork

All Medical Records

Other _____

*Yardley
Dermatology
Associates*

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MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____

To Yardley Dermatology Associates,

I hereby authorize the release of my medical records to:

Doctor, Hospital, Insurance Company, etc.

Address: _____

Phone: _____

Fax: _____

Please send the following:

Recent Biopsy or Bloodwork All

Other _____

Signature of Patient or Legal Guardian

Date