Cooper Clinic™
Dermatology
A COOPER AEROBICS COMPANY

New Patient Dermatology Demographics

Name: _____ Date of Birth: _____ Age: _____

Nickname or preferred name: _____ Sex: ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ ☐Cell ☐Home ☐Work

Secondary Phone: _____ ☐Cell ☐Home ☐Work

Email Address: _____

Do you have other family members who have been treated here? ☐Yes ☐No

How did you find out about or practice? _____

As a healthcare facility, race and ethnicity are required for lab testing and vaccinations. As a Dermatology patient if you do not feel you will be getting either of these or you do not wish to answer the question, you can feel free to check "Patient Declined".

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White

☐Native Hawaiian or Other Pacific Islander ☐Declined

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

EMERGENCY CONTACT

Name: _____ Phone Number: _____

General Consent for Treatment/Consultation

I request and authorize Health Care Services by my physician and his/her designee as deemed advisable. This may include consultations, routine diagnostic, radiology and laboratory procedures, medication administration and retrieval of medication history.

Receipt of Notice of Privacy Practices

I have been given the opportunity to receive a copy of Cooper Clinic's Notice of Privacy Practices.

I understand that information on this form may be changed in writing at any time by contacting Cooper Clinic.

I authorize Cooper Clinic to contact me at the address, phone number and e-mail shown above to send me medical information. I verify that this is the correct information. Failure to indicate the correct information or an illegible address may result in confidential information going to the wrong person or place.

Signature: _____ Date: _____

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Dermatology Financial Responsibility

Thank you for choosing Cooper Clinic as your dermatology provider. We are committed to providing you with the best medical care available. In our ongoing process to make sure all of your medical needs are met; our staff will be available to discuss our fees and this policy with you. **The services you have elected to participate in imply a financial responsibility on your part.**

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept MasterCard, Visa, Discover, American Express, a personal check, debit card, ApplePay, GooglePay or cash.

As the patient (responsible party), please review the following:

1. Your insurance policy is a contract between you and the insurance company. Cooper Clinic and its physicians *are* ***not contracted*** with any insurance companies. Our relationship is with you, not your insurance company. As your medical provider, we can supply you with factual information to facilitate claim processing. Your insurance carrier may not approve or reimburse your medical services due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. We will not become involved in disputes between you and your insurance carrier.

2. I authorize the release of medical records to determine liability for payments, treatment, or to obtain reimbursement.

3. If a package program has been purchased and any portion of the service has been used, it will be non-refundable. Any unused portion will expire one year from the date of purchase.

4. Twenty-four hours advance notice is required for all cancellations and/or rescheduling of appointments to avoid incurring a $75 "no show" fee. A credit card is required to be placed on file when making future appointments and will be used if a no show occurs.

5. If you arrive more than 10 minutes after your scheduled appointment time, you will be required to reschedule your appointment.

I have read and understand the above information.

Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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Authorization to Communicate Confidential Information to Specific Individuals

Name: _____ Date of Birth: _____/_____/_____

I authorize **Cooper Clinic** to communicate my health information to the individuals listed below at my request. Information may be communicated by fax, mail, telephone and email to me, and the individuals listed below (e.g., spouses, relatives, administrative assistants, etc.):

PLEASE PRINT

Individual's Name: _____ Relationship to Patient: _____

☐ Medical Test Results

☐ Non-Medical Information
- ☐ Appointment Information Only
- ☐ Appointment & Billing Information

Individual's Name: _____ Relationship to Patient: _____

☐ Medical Test Results

☐ Non-Medical Information
- ☐ Appointment Information Only
- ☐ Appointment & Billing Information

Individual's Name: _____ Relationship to Patient: _____

☐ Medical Test Results

☐ Non-Medical Information
- ☐ Appointment Information Only
- ☐ Appointment & Billing Information

OR: ☐ Do not communicate with others.

I understand that this authorization may be revoked in writing at any time. I understand that any revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that Cooper Clinic will not condition payment or treatment based upon this authorization for the release of information. I understand that any disclosure of information has the potential for unauthorized re-disclosure, and that the disclosed information may not be protected by federal confidentiality rules.

_____ _____/_____/_____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient

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Dermatology Medical History

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE AS THIS WILL HELP US PROPERLY ADDRESS THE ISSUES IMPORTANT TO YOUR HEALTH:

Please list the purpose of your visit: _____

_____

1. Medical History

Are you currently pregnant? ☐Yes ☐No

Have you ever been diagnosed with any of the following?

- Pre-cancerous skin lesions (Actinic Keratoses)? ☐Yes ☐No If **yes**, please include when and how treated. _____
- Non-Melanoma Skin Cancer? ☐Yes ☐No If **yes**, please include type (if known), when, location, and how treated. _____
- Melanoma? ☐Yes ☐No If **yes**, please include level (if known), when, location and how treated. _____

2. Medications

Do you take any medications on a regular basis? ☐Yes ☐No
(Prescription, non-prescription, supplements, etc.)

If **yes**, please include name and dosage: _____

_____

_____

_____

3. Allergies

Are you allergic to any medications? ☐Yes ☐No

If yes, please list: _____

_____

4. Family History

Have any blood relatives ever had skin cancer? ☐Yes ☐No

If yes, please include which family member and type of skin cancer (if known): _____

_____

_____