Dermatology Associates, Inc.
Oliver A. McKee, MD

Financial Information

We appreciate your help in completing the information requested.

Patient's Full Legal Name:_____ **Social Security #**_____
(First Name Middle Initial Last Name)

Circle: Male / Female **Marital Status:** Married Single Widowed Divorced **Age**____ **Date of Birth**_____

Complete Patient Address: _____ **City**_____ **State**____ **Zip Code**_____

Home Phone(___)_____ **Work** (___)_____ **Cell**(___)_____Which do you prefer we use to contact you?

Patient's E-Mail_____

Employer_____ **Student Status:** FULL / PART TIME

Primary Care Doctor_____ **Address & Telephone#** _____

Referred By Doctor_____ **Address & Telephone#** _____

Insurance Information

Primary Insurance Company_____

Complete mailing address for insurance:_____

Policyholder's Name:_____

Policyholder's Date of Birth: (required)_____ Relationship to patient:_____

Policyholder's SS#: _____ Subscriber ID #: _____ Group :_____

Secondary Insurance Company_____

Complete mailing address for insurance:_____

Policyholder's Name:_____

Policyholder's Date of Birth:(required)_____ Relationship to Patient:_____

Policyholder's SS#:_____ Subscriber ID #: _____ Group #:_____

Dermatology Associates, Inc.

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Please read the following information and sign the form in the two indicated places.

I understand that I am financially responsible for payment of all charges not covered by this authorization or my insurance company. This will include the full cost of any elective or cosmetic procedure(s), or any other procedure not covered by my insurance company, and all reasonable charges incurred in the collection of these charges.

I understand that I am financially responsible for any copayment due at the time of service as required by my insurance company(s). It is also my responsibility to provide a current valid insurance card (s) and photo identification at the time of service, if applicable.

I understand that I will be financially responsible for all charges if I fail to provide complete and accurate information with reference to my insurance company(s) including an absence of an insurance referral required by your insurance plan.

Authorization assign benefits & release of medical information: I hereby authorize my insurance company(s) to make payment for medical services in full directly to Dermatology Associates, Inc. and/or Oliver A. McKee, M.D.

Patient or Responsible Party Signature X _____

Date ___/___/___

RECEIPT OF NOTICE OF PRIVACY PRACTICES: My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature X _____

Date ___/___/___

Dermatology Associates, Inc.

Oliver A. McKee, MD

Medical Information

Patient Name_____ Date of Birth_____

Drug Allergies_____ Reaction_____

Environmental Allergies_____Reaction_____

Current Medications

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Emergency Contact

Name_____ Relationship to Patient_____

Home Phone(____)_____ Work Phone(____)_____

Social History

Frequent use of tanning beds: NO / YES _____ times per month

Frequent Sunburns: NO / YES

Sunscreens: Always / Sometimes / Rarely / Never

Smoking status: (**circle one**)
Current every day smoker
Current some day smoker
Former smoker
Never smoker
Smoker, current status unknown
Unknown if ever smoked

Race: (**circle one**)
American Indian or Alaskan Native
Asian or Pacific Islander
Black
White

Ethnicity: (**circle one**)
Hispanic origin
Not of Hispanic origin

Language: (**circle one**)
Chinese French Japanese Spanish
English German Russian

PLEASE NOTE THAT THE FEDERAL DRUG ADMINISTRATION (FDA) REQUIRES A PATIENT TO BE SEEN ONCE EVERY 12 MONTHS IN ORDER FOR MEDICATIONS TO BE REFILLED BY THE PHYSICIAN. PLEASE SCHEDULE FOLLOW UP APPOINTMENTS ACCORDINGLY.