NEW and/or UPDATED
PATIENT INFORMATION SUMMARY

Robert Allan Breedlove, M.D., F.A.A.D.
Board Certified Dermatologist
STILLWATER SKIN & CANCER MEDICAL CLINIC, INC.
www.breedlovedermatology.com

Today's Date _____ (Mo. Day Year)

Have you ever seen a **DERMATOLOGIST** (Skin Specialist)? Yes ☐ No ☐

Name _____ (Last First Middle) Age _____ Date of Birth _____ (Mo. Day Year)

Circle Applicable: Single Married Separated Divorced Widowed Engaged * * Male / Female

Social Security #_____ Are you a student? _____ Major? _____

Local Address _____ (Street City State Zip)

Permanent Address _____ (Street City State Zip)

Local Phone:_____ Permanent Phone:_____

Regular Physician: _____ Childrens Names & Ages:_____

Employer _____ Position _____

Work Address _____ (Street City State Zip) Phone _____ (Area Local)

Spouse (or responsible party) Name _____ Birthdate_____

Employer Name and Address _____

Occupation _____ Business Phone _____ Spouse's Social Security#_____

Who is responsible for this account?_____ Relationship to Patient _____

Health Insurance Carrier and/or Medicare Number _____

(If needed, please present your health insurance card to the front desk receptionist)

Name & Address of the person(s) who referred you here_____

We expect payment with **each** office visit unless we are filing Medicare, Blue Cross of Oklahoma, State of OK PPO, PPO OK or another accepted 3rd party insurance plan. Please be advised **you** are ultimately responsible for services rendered in any event. If you have insurance you yourself file, you will be given an appropriate form(s) to simply attach to your claim form. REMEMBER, dermatology services are reimbursable the same as other medical services, but your carrier must receive the appropriate forms to render payment.

PERSONAL MEDICAL INFORMATION

Medication allergies? _____ Pregnant? Yes / No

Take any Medication, including Non-Prescription items? _____

Present and/or past treatment(s) for skin problem(s), Date(s), and Physician's Name _____

_____

DO YOU, OR HAVE YOU EVER HAD? (Please Circle All Applicable): High Blood Pressure, Diabetes, Bladder Problems, Stroke, Seizure, Arthritis, Gonorrhea, Syphilis, Herpes Simplex, AIDS, Prostate Infection, Vaginal Infections, Prolonged Bleeding, Hepatitis, Other Liver Problems, Thyroid Disorder, Heart Attack, Enlarged Heart, Poor Circulation, Heart Pacemaker, Valvular Heart Disease, Irregular Heartbeats, Asthma, Hay Fever, Sinus Trouble, Severe Frequent Headaches, Emphysema, Tuberculosis, Ulcers, Gall Bladder Problems, "Nerve" Problems, Psychiatric Problems, or: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____ (Name of Insurance Company)

and assign directly to Dr._____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ (Signature of Insured/Guardian) _____ (Date)

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. 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 services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ (Beneficiary Signature) _____ (Date)