KANSAS CITY
Skin & Cancer Center

PATIENT INFORMATION

(All information is confidential.)

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial) | Date of Birth | Sex | Social Security #

Street Address | Apt# | City | State | Zip

Home Phone | Work Phone | Cell phone | Email Address

LANGUAGE/ETHNICITY/RACE (please circle)

Preferred Language: English or Other _____ Ethnicity: Not Hispanic or Latino/Hispanic or Latino/Unknown

Race: American Indian or Alaska Native/Black or African American/White/Other Race _____

EMERGENCY CONTACT

Emergency Contact | Relationship to Patient | Phone Number

RESPONSIBLE PARTY (If patient is a minor. We do not bill absent parents· the adult present with patient is responsible party.)

Responsible Party | Relationship to Patient | Social Security Number

Address | City | State | Zio

Home Phone | Work Phone | Cell Phone

PRIMARY PHYSICIAN (Please include location or group.) **REFERRING PHYSICIAN** (Please include location or group.)

IMPORTANT INFORMATION/ AUTHORIZATION

I hereby authorize Kansas City Skin & Cancer Center to release any information necessary to secure payment on behalf or on behalf of my dependent. I authorize payment directly to Kansas City Skin & Cancer Center for treatment on any and all services rendered I further understand that I am responsible for all fees not paid by my insurance and the balance is due within 30 days receipt of a patient statement. If my account balance becomes delinquent and is forwarded to an attorney or collection agency, I am responsible for any collection and interest fees, attorney fees and court costs. I certify all information given is try and accurate. A copy of my signature is as valid as the original.

Signature: Date:

ACKNOWLEDGMENT OF HIPAA PRIVACY ACT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, to obtain payment from third-party payers and to conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Kansas City Skin & Cancer Center's Privacy Practices available in the waiting room or upon my request containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact the Privacy Manager to obtain a current copy of the Notice. I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound by such restrictions.

Signature: Date:

8656 N Ambassador Dr. Kansas City, MO 64154 • 9301 W 74th St. Suite 230 Shawnee Mission, KS 66204
Phone: 816.584.8100 Fax: 816.584.8106

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Patient: _____ DOB: _____ Date: _____

Our office sends email and/or text notifications when billing statements are generated. The notification will provide a link to easily make a payment on your account. Please choose which method you prefer to receive your notifications. You can opt out anytime by updating your preferences

_____ Email Confirm your email address: _____

_____ Text Confirm your cell number: _____

_____ Both

_____ None

You can choose to also receive **Online Only** statements. That means, no more lost mail! You can opt in now or opt in later. You can also opt out anytime by notifying our office or updating your preferences through the Account Portal. A notification will be sent to you via your preferred method above when a new bill is available to view. **NOTE:** All delinquent balance notices will be sent by regular mail.

_____ Online Statements Only

_____ I will decide later

Although not required, we encourage all Responsible Parties/Main account holder for family accounts to sign up for the patient account portal. This is separate from your medical records portal. This will allow you to view all current and past statements, make a payment and see payment history, or send a message to our office regarding your bill or to request a detailed receipt for your flexible spending or health savings account.

_____ Sign me up now. Send me an invite to my email address: _____

Other family members (spouse/children) that are patients, I request to be linked to the Account Portal:

_____

_____ No thank you, I'll sign up later.

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CANCELLATION AND NO-SHOW POLICY

We understand that situations arise that require you to cancel your appointment. Therefore, if you must cancel your appointment, please provide more than 24-hour notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours in advance, we are unable to offer that slot to other patients.

Office appointments that are canceled with less than 24-hour notice may be subject to a $35 Cancellation fee.

Patients who do not come to their scheduled appointment without a call to cancel the appointment will be considered a No Show. Patients who No Show two (2) or more times in a 12-month period may be dismissed from the practice and denied any future appointments. Patients may also be subject to a $35 No Show fee.

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived with management approval.

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

_____ _____

Patient Name (PLEASE PRINT) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

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PATIENT INFORMATION

LEGAL NAME: _____

Nickname / Preferred Name: _____

DATE OF BIRTH: _____

PRIMARY CARE DOCTOR: _____

How did you hear about us? *(Please circle one)*

Referred by a doctor: (Name of referring doctor) _____

Friend / Family _____

Internet / Insurance Website

Self

Other: _____

Preferred Local Pharmacy:

Name: _____

Address: _____

_____

Phone: _____

Mail Order Pharmacy: (if applicable)

Name: _____

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HISTORY AND INTAKE

Past Medical History: (Please circle all that apply, past and present. Include dates/year of diagnosis if applicable.)

None
Arthritis: _____
Asthma: _____
Atrial fibrillation (A.Fib): _____
Benign prostatic hyperplasia (BPH): _____
Cerebrovascular accident (TIA/Stroke): _____
Chemotherapy (when/for what?): _____
Chronic obstructive lung disease (COPD): _____
Coronary artery disease: _____
Depression/Anxiety: _____
Diabetes: _____
End-stage renal disease: _____
Epi8lepsy: _____
Gastroesophageal reflux disease: _____
Hearing loss: _____
HIV/AIDS: _____
High Cholesterol: _____
Hypertension: _____
Hyperthyroidism: _____
Hypothyroidism: _____
Hepatitis (type/treatment): _____
Leukemia (CLL or ALL): _____
Lymphoma (type): _____
Breast Cancer: _____
Bladder Cancer: _____
Colon Cancer: _____
Lung Cancer: _____
Prostate Cancer: _____
Radiation therapy
(date(s)/reason): _____
Bone Marrow Transplant: _____

Past Surgical History: (Please circle all that apply, past and present. Include dates/year performed.)

None
Coronary artery bypass graft: _____
Cardiac stent: _____
Heart valve replacement
(Mechanical/biological): _____
Appendix removed: _____
Gallbladder removed: _____
Colon resection/colectomy: _____
Liver removed: _____
Bladder removed: _____
Hysterectomy: _____
Ovaries removed: _____
H/O: tubal ligation: _____
Lumpectomy of breast (right/left): _____
Mastectomy of breast (right/left): _____
Pancreas removed: _____
Prostate removed: _____
Spleen removed: _____
Kidney removed(right/left): _____
Kidney transplant (right/left): _____
Kidney stone removal: _____
Replacement5 of hip joint (right/left): _____
Replacement of knee joint (right/left): _____
Orang transplant (specify): _____

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HISTORY AND INTAKE

Skin Disease History: *(Please circle all that apply. Include dates/treatment if applicable.)*

None
Acne: _____
Actinic keratosis (precancerous lesions): _____
Basal cell carcinoma: _____
Biopsy of skin: _____
Dandruff/itchy scalp: _____
Dry skin: _____
Atypical/Dysplastic moles: _____
Eczema: _____
H/O: Asthma: _____
H/O: Hay fever: _____
Malignant melanoma: _____
Psoriasis: _____
Seasonal allergy: _____
Squamous cell carcinoma: _____

Do you wear sunscreen regularly? YES NO

If yes, what SPF? _____

Do you currently tan in a tanning salon? YES NO

Have you in the past? YES NO

Do you have a family history of melanoma? YES NO

If yes, which relative(s)? _____

Additional family history: _____
_____

_____

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HISTORY AND INTAKE

Medications and Supplements: *(Please list all current medications. **INCLUDING** supplements/vitamins, anything over the counter, AND as needed medications.)*

_____

_____

_____

_____

Drug Allergies/Reaction: _____

_____

_____

Social History: *(Please circle all that apply.)*

Smoking status:
- Current every day smoker (tobacco, cigarette, vape)
- Current some day smoker (tobacco, cigarette, vape)
- Former smoker (when did you quit? _____)
- Never smoked

Sexual History:
- Not sextually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner (male/male, female/female)

Illicit drug use:
- None
- Drug use
- IV drug use

Alcohol use:
- None
- Socially
- Less than 1 drink daily
- 1-2 drinks per day
- 3 or more drinks per day

Safety:
- I feel safe at home
- I do not feel safe at home

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HISTORY AND INTAKE

Immunizations:

Did you receive or decline the annual flu shot? *(Please circle one.)*

YES DECLINE

65 years old and older:

Have you received a pneumonia vaccine?

YES NO

Review of Systems:

Symptoms:

Are you currently experiencing any of the following? *(Please circle "YES" or "NO")*

Immunosuppression	YES	NO
Anxiety	YES	NO
Problems with scarring	YES	NO
Fever or chills	YES	NO
Headaches	YES	NO
Unintentional weight loss	YES	NO
Blurry vision	YES	NO
Depression	YES	NO
Joint aches	YES	NO
Hay fever	YES	NO
Muscle weakness	YES	NO
Problems with bleeding	YES	NO
Changing mole	YES	NO

Alerts:

Do you have any of the following? *(Please circle "YES" or "NO")*

Pacemaker	YES	NO
Defibrillator	YES	NO
Artificial heart valve	YES	NO
Artificial joint within past 2 years	YES	NO
Allergy to lidocaine	YES	NO
Allergy to latex	YES	NO
Pregnancy or planning a pregnancy	YES	NO
Breastfeeding	YES	NO
Allergy to adhesive	YES	NO
Blood thinners	YES	NO
Stomach upset with antibiotics	YES	NO
Yeast infection with antibiotics	YES	NO
Rapid heartbeat with epinephrine	YES	NO
Allergy to topical antibiotic cream/ointment	YES	NO