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:

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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 $50 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 $50 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.

____________________________________	___________________
Print Patient Name	DOB
____________________________________	___________________
Signature of Patient or Patient Representative	Today's Date

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Authorization to Disclose Protected Health Information (PHI)

Patient's Name: ___________________________________**Date of Birth:** ________________

Disclosures to Be Made:

I, _____________________________, hereby authorize KCSCC to speak to the following individual(s) regarding diagnosis, appointment information, and Rx information. This disclosure of my protected health information (PHI) is as described above.

Name: ____
Relationship: _______________________________________
Phone Number: ______________________________________

- ❑ I decline to authorize any individual to have access to my PHI.

Possible Risks:

I understand that the information disclosed under this authorization may no longer be protected by federal privacy laws and could be re-disclosed by the recipient. I have been informed of these risks and have chosen to authorize the disclosure of my health information willingly.

Right to Revoke Authorization:

I understand that I have the right to revoke this authorization at any time by notifying the provider or organization in writing.

Signature: ____**Date:** _______________

This form should be signed in the presence of a healthcare provider, legal representative, or authorized person if applicable.

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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: _______________________
Epilepsy: ___________________________________
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: _________________________
Replacement of hip joint (right/left): ___________
Replacement of knee joint (right/left): __________
Organ 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: ____

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

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

Sexual History:
- Not sexually 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

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HISTORY AND INTAKE

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

____

____

____

____

<u>Drug Allergies/Reaction:</u> ____

____

____

Review of Systems:

<u>Symptoms:</u>

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
Nightsweats	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

<u>Alerts:</u>

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

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Age 65 and older:

Do you have a health care proxy in the event you are unable to make your own medical decisions?

YES NO

If YES: Name and phone number ____

Age 9-13 years:

Have you had the meningococcal vaccine?

YES NO

Have you had the Tdap (Tetanus, diphtheria toxoids, and acellular pertussis) vaccine?

YES NO

Have you had at least 2 HPV vaccines with different dates of service between age 9-13?

YES NO