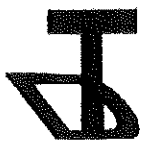

Tareen Dermatology

MEDICAL | SURGICAL | COSMETIC

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Tareen Dermatology New Patient Intake Form

Legal Name: ____ ____________________
First Middle Initial Last Prefer to be called

Date of Birth ____/____/________ Age:________ Sex: ____ Male ____ Female

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ Separated

Mailing Address:____
Street City State Zip

Home Phone:________________( )OK to leave message Cell:________________( )OK to leave message

Occupation: ____________________ Work Phone: ______________Ext: _____( )OK to leave message

Email Address:_____________________________ ☐ I want to receive e-mails on Cosmetic Specials

Emergency Contact:____________________Relationship:__________Phone #:______________

Primary Care Physician and Clinic Name:____

Minnesota State/Federal Government **REQUIRES** we ask the following questions:

Primary Language: ____ English ____ Spanish ____ Somali ____ Chinese Other:________________

Race: ____ Caucasian ____ Asian ____ African American Other:______________________

Ethnicity: ____ Hispanic ____ Latino ____ Not Hispanic or Latino

Responsible Party (if different from patient)

Name:____
First Middle Initial Last

Relationship to Patient: ____

Address:____
City State Zip

Home Phone: ( )____________________ Work: ( )____________________

Date of Birth:____/____/____ Sex: ____ Male _____ Female

Referral (how did you hear about Tareen Dermatology)

Physician and Clinic Name: ____

Family Member: ____

Other: ____

Have you had or currently have any of the following medical conditions:

____ Anxiety	____ End Stage Renal	____ Lung Cancer
____ Arthritis	____ Hearing Loss	____ Lymphoma
____ Asthma	____ Hepatitis	____ MRSA
____ Atrial Fibrillation	____ Hypertension	____ Pacemaker
____ Bone Marrow Transplant	____ HIV/AIDS	____ Prostate Cancer
____ Breast Cancer	____ Hypercholesterolemia	____ Radiation Treatment
____ Colon Cancer	____ Hyperthyroidism	____ Seizures
____ COPD	____ Hypothyroidism	____ Stroke
____ Coronary Artery Disease	____ Immunosuppression	____ Valve Replacement
____ Depression	____ Leukemia	Other:________________
___ Diabetes		

Are you currently: Pregnant ___ Yes ___ No Planning Pregnancy ___ Yes ___ No Breast Feeding ___Yes ___No

Have you had any surgeries? (including joint replacement and heart valve surgeries):

____

____

____

Medications: (including over the counter)

____

____

____

Drug Allergies:

____

____

Do you have or have had any of the following skin conditions?

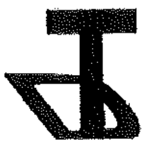
____ Acne	____ Eczema	____ Precancerous Moles
____ Actinic Keratosis	____ Flaking or Itchy Scalp	____ Psoriasis
____ Basal Cell Skin Cancer	____ Hay Fever/Allergies	____ Squamous Cell Skin Cancer
____ Blistering Sunburns	____ Melanoma Skin Cancer	Other:________________
____ Dry Skin	____ Poison Ivy	

Do you have a family history of melanoma or other skin cancers? ____ Yes ____ No

If yes, which relative? What type of skin cancer? ________________________________

Smoking Status:	Alcohol Consumption:
____ Current Every Day Smoker	___ None
____ Current Some Day Smoker	____ Socially
____ Former Smoker	____ Moderate
____ Never Smoked	____ Daily

Pharmacy Name: ______________________________ City/State: ____________________________



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AUTHORIZATION AND CONSENT FORM

General Release of Information & Assignment of Benefits:
I Authorize TAREEN DERMATOLOGY, P.A. on behalf of myself and/or my dependents, to furnish medical records, including films and other information related to health care services provided by TAREEN DERMATOLOGY, P.A. to Medicare, my insurance company or health management organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and file contractors and third party administrators of these parties as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled and I request payment of all such authorized benefits be made on my behalf to TAREEN DERMATOLOGY, P.A. for any services furnished by TAREEN DERMATOLOGY, P.A.

Release of Information by Payers and Networks:
I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from TAREEN DERMATOLOGY, P.A. or any other provider, with TAREEN DERMATOLOGY, P.A., other organizations in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

Payment Agreement:
I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage. If circumstances require the use of a third party collection agency, I understand that I will be responsible for payment of collections costs and/or attorney fees, if necessary.

Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers:
I authorize the release or retrieval of my medical treatment information, including films, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

Messages:
I authorize TAREEN DERMATOLOGY, P.A. to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me. TAREEN DERMATOLOGY, P.A. may call me and, if necessary, leave messages on my answering machine.

Patient Information:
By signing, I acknowledge that I have read and understood the CONSENT FOR THE GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY Form, The Financial Policy Form and the Notice of Privacy Practices (HIPAA Form) from TAREEN DERMATOLOGY, P.A.

I understand all of the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to my revocation.

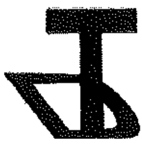
Signature of Patient or Personal Representative ______________________

Patient's Date of Birth ______________________

Today's Date ______________________

Patient's Name (Printed) ______________________

Relationship to Patient (If patient is unable to sign) ______________________



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CANCELLATION & NO SHOW POLICY
Cosmetic Services

Tareen Dermatology requires patients to keep a credit card or debit card on file. This card will only be used to charge a "no-show" or "late cancel" (Less than 24-hour notice) fee in the amount of $150.00 for filler/dysport appointments, and the amount of $95.00 for all other cosmetic services. Along with your credit card or debit card we will need to keep a copy of your valid photo ID in our billing software.

If you do not have a credit or debit card, we require a check in the amount of $150 written out to Tareen Dermatology to be kept on file. We only cash this check in the event of a "no-show" or "late cancel".

An itemized receipt will be mailed to you for any charges made on your card.

Your credit card information is kept on file in our safe, HIPAA compliant electronic practice management software. Our employees do not have access to your credit/debit card number.

Please provide your credit card to our receptionist at the front desk upon check-in, so that we may keep it on file.

By signing this form, I authorize Tareen Dermatology to charge a $150 "no show" or "late cancel" (less than 24-hour notice) fee for filler and dysport appointments, and $95.00 for all other cosmetic services on my account to the credit, debit or check kept on file. I further understand that I will not be given notice in advance of my card on file being charged.

______________________ ______________________ ______________________
Patient Signature **Patient Date of Birth** **Today's Date**

______________________ ______________________
Print Patient Name Witness

*For patients with an emergency situation please talk with our cosmetic coordinator about these fees.