North Pointe Dermatology- Dr. Corinne G Smith

PATIENT INFORMAION *(Please print clearly and completely)*

Patient's First Name: _____ M.I._____ Last Name: _____

Date of Birth: _____ Gender: ☐Male ☐Female ☐Other Last 4 digits SSN: _____

Address: _____

City_____ State_____ ZIP_____

Phone#: Cell # _____Home# _____Preferred Contact #_____

Email: _____ ☐*Okay to text/leave message*

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

Employment Status: ☐Full time ☐Part time ☐Unemployed ☐Retired ☐Student ☐Other _____

Name of Parent/Guardian/Spouse_____Phone #:_____

Address *(If different)*:_____

Emergency Contact: _____Relationship:_____Ph #_____

How did you hear about us? _____ Referring Person Name: _____

INSURANCE INFORMATION (*Please present insurance cards at time of check-in)*

Primary Insurance Name _____ Secondary Insurance name_____

Name of Insured _____DOB_____ Name of Insured _____DOB_____
Insurance ID #_____ Insurance I.D. #_____
Group #_____ Group #_____
Insurance Phone #_____Insurance Phone # _____

Pharmacy Name/Location_____Phone#_____Fax#_____

Laboratory Provider for Insurance plan_____

Primary Care Doctor (PCP):_____ PCP Phone# _____Fax#_____
(Please fill completely: Mark N/A if you do not have a PCP or do not want to share the information)

I authorize the release of medical information to North Pointe Dermatology as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I acknowledge that full payment is required at the time of service unless I have an insurance plan in which Dr. Smith participates, in which case applicable deductible and copayment/ coinsurance amounts will be collected at the time of service. I understand that a fee may be charged if appointments are not cancelled/rescheduled at least 24 business hours prior to my appointment time.

Patient/Guardian Name_____Relationship_____

Patient/Guardian Signature_____Date_____/_____/_____

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Patient History Form

NAME_____ **DOB**_____ **Age**_____

Preferred 1st Contact #_____ Home/Cell ☐ *Okay to leave message*

Preferred 2nd Contact #_____ Home/Cell ☐ *Okay to leave message*

Referred By: ☐*Doctor* ☐*Coworker* ☐*Family/Friend* ☐ *Website* ☐ *Other*_____

Family History:

Has any member of your family been seen by Dr. Smith? ☐ ***Yes*** ☐ ***No*** *If yes, please list:*

Family Member Name	Relation	Illness

Does any members of your family has skin cancer? ☐ ***Yes*** ☐ ***No*** *If yes, please list*:

Family Member Name /Relation	Type of Cancer	Location	Treating doctor

Personal History:

Do you have a personal history of skin cancer? ☐ ***Yes*** ☐ ***No*** *If yes, please list:*

Type of Skin Cancer	Location	Year	Treating Doctor

Do you have a history of any other health issues? ☐ ***Yes*** ☐ ***No*** *If yes, list the illness & treating doctor*:

_____
_____
_____
_____

Do you take any medications? ☐ ***Yes*** ☐ ***No*** ***If yes, please list on Form-3- Medication list completely***

Do you have any Allergies? ***Medications*** ☐ ***Yes*** ☐ ***No*** ***Others*** ☐ ***Yes*** ☐ ***No*** ***If yes, please list on Form 3***

Social history:

Occupation: _____ **Hobbies:** _____

Please list how often you engage in the following activities:

Alcohol: _____Tobacco: _____

Tanning bed use: _____ Exercise: _____

Patient/Guardian Signature_____**Date**_____/_____/_____

NPD Patient Medication list

Patient Name: _____ **DOB**: _____

Allergies: _____

Primary care Dr. Name: _____Ph #/Fax#_____

Prescription Medications:

Name	Dosage	Directions	Prescribing Dr	Start date	End date

Over the Counter Medicines:

Name	Dosage/Directn	Start	Name	Dosage/Directn	Start

Supplements:

Name	How often	Name	How often

Patient /Guardian Signature: _____Date: _____

Meds reviewed (NPD Staff only):

Date	MA	Date	MA	Date	MA	Date	MA	Date	MA

Continued from Page 1 of NPD Medication List

Patient Name: _____ **DOB**: _____

Prescription Medications:

Name	Dosage	Directions	Prescribing Dr	Start date	End date

Over the Counter Medicines:

Name	Dosage/Directn	Start	Name	Dosage/Directn	Start

Supplements:

Name	How often	Name	How often

Patient /Guardian Signature: _____Date: _____

Meds reviewed (NPD Staff only):

Date	MA	Date	MA	Date	MA	Date	MA	Date	MA

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Appointment Cancellation/Late & No-Show Policy

Recognizing that everyone's time is valuable and the appointment time is limited, NPD has established a cancellation and no show policy that helps us to provide efficient and effective care to all our patients.

Our office provides courtesy reminder phone calls to all our patients for their appointment. However, it is patient's responsibility to come to their scheduled appointment in a timely manner or call our office for any changes to their scheduled appointment in a timely manner. Please remember, each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, NPD will charge fee of $ 35.00 to $50.00 for improperly cancelled, missed or late appointments.

24 business hour Cancellation Notice: NPD requests its patients to provide a 24 business hour cancellation notice so that we can schedule one of the patients from our waiting list. Any scheduled screen and cosmetic appointment that is not cancelled with a 24 business hour advance notice from the actual time of your appointment, might be charged a late fees of $ 50.00 and all other appointments will be charged a late fee of $ 35.00.

Same day Cancellations and No show: A fee of $ 35.00 for follow-up appointments and $ 50.00 for screen and cosmetic appointments will be charged to all patients who do not show up for their scheduled appointment or cancel their appointment on the same day of their appointment.

Late arrivals: Patients who arrive late to their scheduled appointment time by 10 or more minutes, might need to be rescheduled. We will do our best to work you in if we possibly can.

Thank you for your support in helping us in providing efficient and effective medical care to all our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

Name of the Patient_____

Signature of patient/ Guardian _____**Relationship to Patient** _____

Date _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, do hereby confirm that a copy of
(Print Name Here)

Corinne G. Smith, M.D., P.C.'s Notice of Privacy Practices has been made available for my review.

Name of the Patient_____

Signature of patient/ Guardian _____**Relationship to Patient** _____

Date _____