Jennifer Stalkup, MD, PA
PLANO DERMATOLOGY

PATIENT HEALTH HISTORY
Today's Date: _____

Full Name (Last, First, MI, "Nickname") Date of Birth Gender

Address Email

Provide your contact number(s) and check the box below for your preferred contact number.

Mobile Home Work
May we leave a detailed message? Yes _____ No _____

Emergency Contact Phone

Pharmacy Name Pharmacy Address Phone

Primary Care Provider (PCP/Internist/Family Doctorl) Phone

Referring Provider (if your insurance requires a referral) Phone

INSURED'S INFORMATION

Name of Insured Date of Birth

Primary Address Phone (Home/Cell)

Driver's License # Social Security #

Relationship: Spouse/Partner/Father/Mother/Son/Daughter/Sibling

Occupation Employer Work Phone

Employer's Address City State Zip Code

IN CASE OF EMERGENCY CONTACT(S)

Name(s) Relationship(s)

Address Phone number(s)

PRIMARY INSURANCE CARRIER

Name of Primary Insurance Company	Mailing Address for Insurance Claim
Name of Policy Holder	Relationship to policyholder

Name of Employer	Group Number	ID or Policy Number
Effective Date of Policy	Phone # for Verification	Phone # for Pre-Certification

SECONDARY INSURANCE CARRIER

Name of Secondary Insurance Company	Mailing Address for Insurance Claim
Name of Policy Holder	Relationship to policyholder

Name of Employer	Group Number	ID or Policy Number
Effective Date of Policy	Phone # for Verification	Phone # for Pre-Certification

JENNIFER STALKUP, MD, PA
Payment Policy

We will file insurance for our PPO patients. **However, all co-payment and/or deductible amounts are due at the time of the service**. Any disallowed amounts are due from the patient.

We do not file insurance for our indemnity patients. Payment in full is expected at the time of visit and a receipt will be given for you to file with your insurance carrier.

There will be a $25.00 fee assessed for any returned check. This fee is assessed regardless of whether the check is deposited, because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount.

If your account has a credit balance of more than $10.00, a refund will be mailed to you within 30 days.

Your insurance policy is a contract between you and your insurance company. It is important that you understand what physician services are and are not covered before seeing the doctor.. We cannot guarantee payment of your claims by your insurance company. Reduction/ rejection of your claim by your insurance company **does not** relieve the financial obligation you have incurred.

Please acknowledge our payment policy by signing your name and dating the form. Thank you!

Signature _____ **Date** _____

MEDICARE

We accept assignment and will file insurance for our Medicare patients. However, any calendar year deductible amounts (up to the amount of the visit) are due at the time of service. We will also file secondary insurance after payment from Medicare if we are contracted with your secondary plan, If there is no secondary insurance, the patient will be billed for any remaining balance.

REFERRAL AUTHORIZATION

Referrals must be obtained prior to the visit. If a referral is not received at the time of the visit, the patient can either reschedule the appointment or pay the amount of the services rendered.

AUTHORIZATION

I authorize release of medical records to determine liability for payments or treatment and to obtain reimbursement. I assign all medical benefits for office visits to Jennifer Stalkup, MD, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

_____

_____

Signature Date

NOTICE OF PRIVACY PRACTICES AND PROTECTIONS OF HEALTH INFORMATION

Our Notice of Private Practices (notice) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by request from the receptionist.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this Form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I may revoke this consent at any time, except where information has already been released. The consent is valid until revoked by me in writing.

_____

Signature Date

REASON FOR VISIT

Concern: _____

Body Part: _____ Duration: _____

Previous/Current Treatment: _____

MEDICAL HISTORY

Please circle past and present medical conditions you have experienced:

None	Depression	Lung problems/shortness of breath
Anxiety	Diabetes	Muscle weakness
Arthritis	Fever/chills	Night sweats
Asthma/allergies	Headaches/migraines	Thyroid problems (hypo or hyper)
Atrial fibrillation	Heart problems/Chest pain	Stroke
Bleeding problems	Hepatitis	Unintentional weight loss
Bone marrow transplant	HIV/AIDS	
Other:_____		
Bowel disease/pain	Immunosuppression	

_____

Cancers other than skin:*Include type/location/treatments*: _____

_____

PAST SURGERIES

_ None OR List all past surgeries: _____

SKIN DISEASE HISTORY

If you have had any of the following skin conditions, provide details below (including previous/past treatments and location(s)) or circle **NONE**

SKIN CANCERS (circle)	**SKIN CONDITIONS** (circle)
Basal Cell Carcinoma _____	Acne _____
Squamous Cell Carcinoma _____	Eczema _____
Melanoma _____	Psoriasis _____
Dysplastic (atypical) moles _____	Autoimmune _____

Additonal skin conditions _____

Do you wear Sunscreen? Y / N Tanning salon usage? Y / N UV exposure? Y / N

Do you have a family history of Melanoma? Y / N If yes, which relatives(s)? _____

MEDICATIONS

List all medication names/dosages including prescription creams and OTC meds/supplements or circle **NONE**

_____

_____
_____
_____

ALLERGIES

Circle **NONE** or **LIST** _____

SOCIAL HISTORY (please circle)

TOBACCO USE: Never/Current If yes: Total years _____ Packs/day _____ Type _____

ALCOHOL USE: Never 1 drink/day 1-2 drinks/day 3 or more drinks/day

OCCUPATION: _____

ALERTS

Select all that apply:

_ Are you pregnant or trying to get pregnant?
_ Do you require antibiotics prior to a teeth cleaning or surgical procedure?
_ Do you have an artificial joint? Location: _____
_ Do you have a pacemaker/defibrillator? (please circle)
_ Do you have a history of fainting to needle injections/blood draws?
_ Do you have an allergy to lidocaine? adhesive? topical antibiotic? (please circle)
_ Have you had the COVID-19 vaccination? If yes, please list dates of when: #1) _____ #2) _____

DISCLOSURE OF PERSONAL INFORMATION

I, _____, give the office of Jennifer Stalkup, MD, PA permission to speak with the following family members, spouse, partner, roommates, etc, regarding any billing issues, lab results, or any information pertaining to my treatment/care.

_____ _____
_____ _____

ATTESTATION TO CORRECT INFORMATION

I, _____, hereby certify that the above statements are true and correct to the best of my knowledge.

Signed: _____ Date: _____

(This will expire in 12 months from the above date.)