DERMATOLOGY & CUTANEOUS SURGERY
MICHAEL E. MCCADDEN, M.D.
EMILY BECK, M.D.

PLEASE PRINT

New patient___ Name change___ Address change___ Insurance change___

Patient Information

____
Last Legal First Name M.I.

Date of Birth:____/____/____ Sex: Male___ Female___ Marital Status_______

Mailing Address____
Street Apt#

______________________________ ______________ ____________________
City State Zip

Personal e-mail address:____

Home Phone:( )___________________ Cell Phone:( )______________________

Work Phone:(___)________________________ ext_____________________________

Parent, Spouse, responsible party and/or INSURED (if different from patient)

Name:____ DOB:_____/_____/_____

Last 4 digits of SS#_________________________________

Relationship to patient: spouse father mother guardian other **please circle**

INSURANCE CARRIER INFORMATION

Primary Insurance Carrier:____

Secondary Insurance Carrier:____

If MEDICARE is your SECONDARY insurance we need the name of the EMPLOYER that your primary insurance is through. Without this information we cannot bill Medicare.

Employer:____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or the party who accepts assignment.

Date:_____/_____/_____ Signature____
Must be over 18 years old to sign

DERMATOLOGY & CUTANEOUS SURGERY
MICHAEL E. MCCADDEN, M.D.
EMILY BECK, M.D.
314-251-3376

Patient Name:_________________________________ Today's Date____/____/____

Other family members that are patients:______________________________________

Primary Care Doctor's First and Last name and phone #__________________________

Pharmacy phone number_________________________________

EMERGENCY CONTACT INFORMATION

In case of emergency who should be notified?_________________________________

Phone: (   )____________________ Relationship to patient:__________________

May we leave personal medical information on your answering machine or cell phone? YES ( ) NO ( )

To remain HIPAA compliant, who do you give us permission to discuss your medical information with?

No one _______ (please initial)

Name:___________________________________ Relationship:_______________
Name:___________________________________ Relationship:_______________
Name:___________________________________ Relationship:_______________

RECEIPT OF NOTICE OF PRIVACY PRACTICES
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Privacy Practices). **Pamphlets available in reception/lobby area.**

Patient or Responsible Party Signature_________________________ Date:___/___/___

PAYMENT POLICY
Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay for any deductible amount, co-insurance or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLING ALL COPAYMENTS, AS WELL AS FEES FOR COSMETIC SERVICES, MUST BE PAID AT THE TIME OF SERVICE.

______(**PLEASE INITIAL**) If this account is referred to an attorney or an outside agency for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collections.

Patient or Responsible Party Signature______________________ Date____/____/____

DERMATOLOGY & CUTANEOUS SURGERY

Patient Name_______________________________________ DOB________________________

Preferred language________________ Refuse   Are you Hispanic or Latino? Yes No Refuse

Race: (Please Circle)   White   Black or African American   Asian
American Indian or Alaska native   Native Hawaiian or Other Pacific Islander   Refuse

Smoking Status: (Please Circle) Current everyday smoker   current someday smoker   unknown
Former smoker   smoker current status unknown   never smoked   refuse

Do you have or have you had any serious chronic illness, surgeries? Immunosuppressed?
Please list____

Do you have any drug allergies? Please list along with type of reaction and severity.____

Are you allergic to latex, band-aids, tape, or any antibiotic ointment? Yes_____ No_______
Please explain:____

Have you had any skin cancer? Yes_______ No_______
If yes, what type and when?____

Is there a family history of skin cancer? Yes______ No_______

Is there any family history of melanoma? Yes______ No_______
If yes, what relation?____

Is there a family history of any chronic illness? (heart disease, diabetes, cancer, high blood pressure, ect.) Please list illness and family relationship. ____
____

Do you have any chronic or recurrent problems with the following categories?

PLEASE PLACE AN "X" IN THE BOX FOR YES ANSWERS

Eye dryness	Diarrhea	Excessive bleeding
Eye itching	Nausea	Enlarged lymph nodes
Eye sensitivity to light	Acid reflux	Artificial body parts
Hay fever or allergies	Swelling in legs	Trouble healing
Ear scaling, itch or rash	Facial flushing	Shortness of breath
Chronic sinus infection	Tingling in fingers/toes	Asthma
Migraines	Numbness in finger/toes	High stress
Genital itch or discharge	Cardiac or other stents	Anxiety
Burning w/urination	Mitral valve prolapse	Joint pain
Fatigue/lethargy	Pacemaker	Arthritis
Unexplained weight loss	Defibrillator	Smoke cigarettes
Unexplained weight gain	Cold intolerance	Pregnant

Do you want the provider to perform a whole-body skin exam as part of the initial evaluation?
Yes, I want my entire skin examined (please initial)________
No, I do not want my entire skin examined (please initial)________

____   ____________________
Patient Signature   Date

DERMATOLOGY & CUTANEOUS SURGERY
MICHAEL E. MCCADDEN, M.D.
EMILY BECK, M.D.

Patient Name___________________________________ Date_______________
DOB____________________
Primary Care Doctor Name and phone number__________________________________
Pharmacy Name and Phone Number____

Drug Allergies, type of reaction, and severity of reactions_________________________
____
____

I do not take any prescription medications_____ (please initial)
I do not take any over the counter medication or supplements____ (Please initial)
I have no drug allergies that I am aware of_____ (please initial)

Please include all prescriptions prescribed by other doctors, over the counter medications, and supplements below. (We have a list of the medications that WE prescribe you)

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Patient Signature______________________________________ Date_______________

Medication list continued

Patient Name_________________________________ Date_____________
DOB______________

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Medication____
Dose____
Directions____
Date started____
Prescribed by Dr.____

Patient Signature___________________________________ Date______________

DERMATOLOGY & CUTANEOUS SURGERY

MERCY DOCTORS BUILDING
621 S. NEW BALLAS ROAD
TOWER A – SUITE 498
ST. LOUIS, MO 63141
(314) 251-3376
FAX (314) 251-5781

DIPLOMATE AMERICAN BOARD
OF DERMATOLOGY
FELLOW AMERICAN ACADEMY
OF DERMATOLOGY

OFFICE POLICY

Welcome to Dermatology & Cutaneous Surgery, Inc. We are committed to providing excellent dermatologic care in a compassionate and caring environment. We look forward to serving all of your dermatologic needs. Our success is measured by your satisfaction.

1. Normal office hours to conduct regular business issues such as appointments, prescription refills, lab results, insurance questions, account balances, and nonemergency calls are Monday-Friday 8:00am to 4:30pm.
2. All fees the patient is responsible for, including co-payments, are due at the time services are rendered. There will be $40.00 fee charged to your account for each check returned to us for insufficient funds.
3. We request established patients to arrive at least a few minutes before your appointment time, to ensure that all necessary forms have been completed. Also, it is easier for us to run on time if the patients show up as scheduled. Remember to leave time for parking. Valet parking is available in front of Tower A.
4. **No show policy.** Your health is important to us, and it is important for you to keep your scheduled appointments. When patients miss appointments without calling the office to cancel, we lose the ability to offer those appointment times to other patients who would like to see us. We require a 24 hour notice to change or cancel a scheduled appointment. **If you fail to show or cancel your appointment without a 24 hour notice you will be charged $40.00**. These charges are the **patient's responsibility** and cannot be billed to your insurance company. **If you fail to show for a surgical/procedure appointment, the fee will be ½ of what the procedure fee would have been.**
5. If you move or change your telephone number please notify us immediately. If you receive a new insurance card please present that to the receptionist at the time of your next appointment.
6. In the event any action is taken to enforce collection of this account, the prevailing party will be entitled to recovery of all legal fees incurred.

The undersigned certifies that he/she has been informed and has read the foregoing and is the patient, or is duly authorized by the patient's general agent to execute the above and accept its terms.

Signature____ Date_________

Witness____ Date__________

DERMATOLOGY & CUTANEOUS SURGERY
MICHAEL E. MCCADDEN, M.D.
EMILY BECK, M.D.

ST. JOHN'S MERCY DOCTORS BUILDING
621 S. NEW BALLAS ROAD
TOWER A – SUITE 498
ST. LOUIS, MO 63141
(314) 251-3376
FAX (314) 251-5781

DIPLOMATE AMERICAN BOARD
OF DERMATOLOGY
FELLOW AMERICAN ACADEMY
OF DERMATOLOGY

HIPAA RELEASE

I authorize the office of Dermatology and Cutaneous Surgery to release my PHI (personal health information) to:

______________________________ relationship to patient _________________________

______________________________ relationship to patient _________________________

______________________________ relationship to patient _________________________

____
Signature Patient/Guardian

____ ______________________
Witness Date