PRIZANT DERMATOLOGY

Tracy L. Prizant, M.D.

Diplomate of the American Board of Dermatology
Practice Limited to Dermatology

APPOINTMENT _____ TIME _____

Prizant Dermatology office policy states patients must update medical history forms every two years. Enclosed please find these forms for you to complete and bring to your appointment.

Please list your medications (or attach a list) along with their dosage and reason you are taking. Providing us with your ***pharmacy name, zip code and/or telephone number*** will allow us to send your prescriptions from Dr Prizant directly to your pharmacy using our E-prescribe computer program. Please bring the following with you for check-in.

Insurance card(s)
Photo ID
Co-pay
Paperwork

You are required by your insurance plan to pay your co-pay the day of your appointment. Your health insurance is intended to cover some, but not necessarily all of the cost of your treatment. Most plans include co-insurance and/or deductibles, which may be billed to you after insurance processing.

If your insurance requires a referral from your primary care physician, we must have the referral faxed to the office prior to the day of your appointment. If there is no referral, you will be asked to reschedule.

If a patient has no health insurance and is considered self-pay, those fees are to be paid the day of service.

Procedures, such as the removal of skin tags, milia, acne surgery, treatment of unwanted blood vessels, and others, are generally considered to be cosmetic and are not covered by health insurance. *Patients will be responsible for these charges on the day of service.*

Other cosmetic services offered include botox, dermal fillers, and chemical peels.

We accept cash, personal checks, Visa, MasterCard, Discover, and American Express.

We are located on Baum Boulevard between the cross streets of South Negley and South Euclid Avenues. Free parking is available adjacent to our building, there is outdoor parking and a small garage, both areas are available for our patients. You may get a map with directions and other helpful information by visiting our website at www.Prizantderm.com.

If you find you must cancel or reschedule your appointment, please call our office at least 24 hours in advance. Our phone hours are Monday through Friday 7:30 am to 4:30 pm.

THANK YOU

5770 Baum Boulevard, Suite 200 • Pittsburgh, PA 15206
412-363-SKIN (7546) • Fax 412-924-0700

Prizant Dermatology Patient Registration

NAME _____ DATE OF BIRTH _____

Record Release Authorization / HIPAA

I authorize Prizant Dermatology and its' agents to release routine information pertaining to my evaluation and treatment, to their agents, insurance carriers, my primary care physician, a consulting physician, or myself to aid in my medical treatment. My protected health information may be used and disclosed by Dr Prizant and her staff that are involved in my care and treatment for the purpose of providing health care services to me, to pay my health care bills, to support the operation of the physician's practice and other use required by law. Notice of HIPAA Privacy Practices brochure is available upon request.

SIGNATURE_____ **DATE**_____

All Insurance Carriers

I authorize that payment on my behalf be made directly to Prizant Dermatology for all covered charges and services not paid by me. I have read and understand the billing policies of Prizant Dermatology, and I agree to pay Prizant Dermatology for all charges that are not covered or are denied by the applicable insurance carrier. This agreement pertains to coverage by all private, managed care, and government insurance carriers.

SIGNATURE_____ **DATE**_____

Test Results

Please check one option below

☐ **I want to speak directly with the office staff to receive my test results**
***Please note, if we get your voicemail when calling, a message will be left for you to call the office so that we may speak directly with you**

☐ **Test results may be left on my voicemail or given to the following individual(s)**

_____

_____

SIGNATURE_____ **DATE**_____

THE ABOVE SIGNED AUTHORIZATIONS ARE TO BE CONSIDERED VALID AS LONG AS I AM UNDER THE CARE OF PRIZANT DERMATOLOGY UNLESS REVOKED BY WRITTEN REQUEST

Prizant Dermatology Patient Registration

Patient name			
Date of birth / age			
Address city / state / zip			
Phone numbers			
Social Security #			
Place of work / Occupation			
Emergency contact/ relationship / phone			
Email			
Primary care physician			Referred ☐Yes ☐ No
Marital Status	☐ Married ☐ Single ☐ Widowed ☐ Divorced		Weight
Gender / Race	☐ Male ☐ Female	☐ White ☐ Black/ African American ☐ Asian ☐ American Indian ☐ Unspecified	
Smoking status ☐ Current ☐ Former ☐ Never	Alcohol use ☐ None ☐ 1 to 2 drinks/day ☐ 3 or more		Currently pregnant ☐ Yes ☐ No
Pharmacy Name	Address / Zipcode		Phone number

Medications

Medication name	Dosage	Frequency	Reason taking

Allergies

Patient Signature (guardian if under 18) _____ Date _____

Tracy L Prizant MD signature _____ Date _____

Prizant Dermatology Patient Registration

NAME _____ DATE OF BIRTH _____

Past Medical History

CONDITION			CONDITION		
ANXIETY	YES	NO	HIV / AIDS	YES	NO
ARTHRITIS	YES	NO	HIGH CHOLESTEROL	YES	NO
ASTHMA	YES	NO	HYPERTHYROIDISM	YES	NO
ATRIAL FIBRILLATION	YES	NO	HYPOTHYROIDISM	YES	NO
BREAST CANCER	YES	NO	JOINT REPLACEMENT LIST AREA	YES	NO
COLON CANCER	YES	NO	KIDNEY DISEASE	YES	NO
COPD	YES	NO	LEUKEMIA	YES	NO
CORONARY ARTERY DISEASE	YES	NO	LUPUS	YES	NO
DEPRESSION	YES	NO	LYMPHOMA	YES	NO
DIABETES	YES	NO	PROSTATE CANCER	YES	NO
GERD (REFLUX)	YES	NO	SEIZURES	YES	NO
HEARING LOSS	YES	NO	STROKE	YES	NO
HEPATITIS (A B C)	YES	NO	TRANSPLANT	YES	NO
HIGH BLOOD PRESSURE	YES	NO	TUBERCULOSIS		
OTHER					

Dermatological History

CONDITION	SELF	FAMILY MEMBER	CONDITION	SELF	FAMILY MEMBER
ACNE			HAIR LOSS		
ACTINIC KERATOSES			MELANOMA SKIN CANCER		
BASAL CELL SKIN CANCER			PSORIASIS		
BLISTERING SUNBURNS			ROSACEA		
ECZEMA			SQUAMOUS CELL SKIN CANCER		
FLAKING / ITCHING SCALP			WARTS		
OTHER					

Review of Systems

ALLERGY TO ADHESIVES	YES	NO	HEADACHES OR DIZZINESS	YES	NO
BLEEDING OR CLOTTING PROBLEMS	YES	NO	MUSCLE WEAKNESS	YES	NO
BOWEL OR BLADDER PROBLEMS	YES	NO	RASH	YES	NO
CHANGE IN MOLE OR SKIN LESION	YES	NO	SHORTNESS OF BREATH	YES	NO
FEVER AND CHILLS OR FATIGUE	YES	NO	UNINTENTIONAL WEIGHT LOSS	YES	NO

PLEASE NOTE

PROCEDURES THAT ARE CONSIDERED TO BE *COSMETIC* BY YOUR HEALTH INSURANCE
AND THE DOCTOR ARE NOT COVERED BY HEALTH INSURANCE AND PAYMENT WILL BE COLLECTED AT THE TIME OF SERVICE

PATIENT SIGNATURE (GUARDIAN IF UNDER 18) _____ DATE _____