

PRIZANT DERMATOLOGY

TRACY L PRIZANT MD

5770 BAUM BOULEVARD #200 PITTSBURGH, PA 15206

412-363-SKIN (7546) Fax 412-924-0700

APPOINTMENT DATE _____ TIME _____

Enclosed are forms for you to complete and bring with you to your appointment. If you are an established patient, this is an update, please complete as requested. 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 Prizant Dermatology directly to your pharmacy using our E-prescribe computer program. It is important to bring the following with you for check-in:

Insurance card(s) ----- Photo ID ----- Co-pay (if required) ----- This 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.

Patients with no health insurance are 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, chemical peels, SkinPen microneedling for acne scarring and facial rejuvenation along with PRP for hair loss.

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

Our office is 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 an outdoor parking lot and a small garage, both areas are available for our patients. There is also street parking that payment at parking kiosk is required.

You may get a map with directions and other helpful information by visiting our website 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 4:00 pm.

THANK YOU

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 <input type="checkbox"/> Yes <input type="checkbox"/> No
MARITAL STATUS	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	WEIGHT
GENDER / RACE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK/ AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> UNSPECIFIED	
SMOKING STATUS	ALCOHOL USE	CURRENTLY PREGNANT
<input type="checkbox"/> CURRENT <input type="checkbox"/> FORMER <input type="checkbox"/> NEVER	<input type="checkbox"/> NONE <input type="checkbox"/> 1 TO 2 DRINKS/DAY <input type="checkbox"/> 3 OR MORE	<input type="checkbox"/> YES <input type="checkbox"/> NO
PHARMACY NAME	ADDRESS / ZIPCODE	PHONE NUMBER

MEDICATIONS

MEDICATION NAME	DOSAGE	FREQUENCY	REASON TAKING

ALLERGIES

REACTION DETAILS

PATIENT SIGNATURE (GUARDIAN IF UNDER 18) _____ DATE _____

TRACY L PRIZANT MD _____ DATE _____

PRIZANT DERMATOLOGY PATIENT REGISTRATION

NAME _____ DATE OF BIRTH _____

PAST MEDICAL HISTORY					
CONDITION	YES	NO	CONDITION	YES	NO
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	YES	NO
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					
	YES	NO		YES	NO
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 _____

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 NOTIFICATION

The office will phone you in approximately 7 to 10 days with your test results. If we do not reach you directly, a message may be left on your voicemail, or may be 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