10485 N. PENNSYLVANIA ST, SUITE 150 **BOOTH DERMATOLOGY GROUP** 320 N. MERIDIAN ST. SUITE 110
INDIANAPOLIS, IN 46280 INDIANAPOLIS, IN 46204

WELCOME

Appt. Date & Time:____

Patient's Name: ____

Welcome to Booth Dermatology & Cosmetic Center. Thank you for choosing us for your dermatological needs.

Please note, if a patient is under 18 years of age, a parent or guardian must complete paperwork and attend the appointment with the minor. If the patient is 18 years of age or older, the patient must complete his/her own paperwork. We are required to update your paperwork every year even if there are no changes. We do appreciate your cooperation with this matter.

We can be reached at 317-848-2427. Our office hours are Monday through Friday, 8:00 AM – 5:00 PM (with lunch from 12:00 – 1:00 PM).

After you have completed your patient paperwork, please bring with it you. Please be sure that we have your insurance information.

We are looking forward to meeting you, and if you have any questions, please don't hesitate to call us at 317-848-2427.

Thank you,

Dr. Sally A. Booth

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PATIENT INFORMATION

Last name: ___________________________________ First: _________________________ MI: ______
Address: ____
City/State: ____ Zip: __________________
Email: ____
Home Phone # ____________________________ Work/Cell # _______________________________
Date of Birth: ______/______/______ Age: ______ Ethnicity: ___________Gender: ____Male ____Female____
Social Security #: ________________ Marital Status ______ Referred by: ______________
Employer: ______________________________________ Occupation: _______________________
Physician: ______________________________________ Phone #: __________________________

INSURANCE INFORMATION

Name of Insurance Company: ____
ID #: ______________________________________ Group #: _______________________
Name of insured: _____________________________ Insured D.O.B: ______/______/______
Relationship to Patient: _______________________ Do you have a copay? _____________
Do you have a deductible? YES NO If so, How much? ______________

MEDICARE SIGNATURE:

I request that payment of authorized Medicare benefits to me or on my behalf to Booth Dermatology Group, P.C., for any services furnished me by Booth Dermatology Group, P.C. I authorize any holder of medical or other information about me to release to the Center for Medicare & Medicaid Services and its agents, any information needed to determine these benefits or benefits for related services.

X________________________________ _________
Signature of Patient or Legal Guardian Date

CONSENT TO TREAT SIGNATURE:

By signing this form, I authorize the physicians and employees of Booth Dermatology Group to provide medical or surgical care and services. In the course of my medical care, I agree to comply with the plan of care/services to which I have consented.

X________________________________ _________
Signature of Patient or Legal Guardian Date

INSURANCE BILLING SIGNATURE:

I request that payment of insurance benefits be made either to me or on my behalf to Booth Dermatology Group, P.C., for any services furnished me by that physician/provider/supplier. I authorize any holder of medical information or other information about me to release to my insurance company and its agents, any information needed to determine these benefits or the benefits payable for related services.

X________________________________ _________
Signature of Patient or Legal Guardian Date

EMAIL CONSENT SIGNATURE:

I give consent and authorization for Dr. Booth's office to add me to their E-mail list, in order for us to communicate via E-mail.

X________________________________ _________
Signature of Patient or Legal Guardian Date

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PATIENT NAME: ________________________________ **DOB**: ______/______/______

Have you used any prescription creams or topical preparations in the last two months? If so, please list them:
____

Please list any home remedy or over the counter preparations used in the last two months:
____

Cortisone meds in past year? YES NO Oral contraceptives? YES NO ALLERIGES? _________________

Reaction to medication? _________________________ Skin sensitivities? ________________________________

Please circle any medical conditions you may have or may have had:

diabetes	hepatitis	bleeding tendency	stomach ulcer
cancer	pacemaker	heart disease	asthma
cataract	arthritis	rheumatic fever	kidney disease
convulsions	tuberculosis	glaucoma	phlebitis/blood clot
hay fever	eczema/psoriasis	high blood pressure	others

Include all surgeries: Any problem with anesthetic? YES NO

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. ____________________________________
7. ____________________________________
8. ____________________________________

Comments:

Please state any medical conditions which family members father, mother, brother, sister may have had.
____
____

Any personal or family history of melanoma or skin cancer? YES NO

Pregnant or planning a pregnancy? YES NO

Reason for today's visit? ____

Today's Date: _________________________

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PATIENT NAME: ________________________________ **DOB**: ______/______/______

MEDICATION LIST

List your current medications (prescription and over the counter)
If you take NO medications, initial here: __________

DRUG **DOSAGE** **EXPLAIN (if necessary)**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____
17. ____
18. ____

REVIEW: (1) initials date (2) initials date (3) initials date (4) initials date (5) initials date
(6) initials date (7) initials date (8) initials date (9) initials date (10) initials date

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PRIVACY PRACTICES ACKNOWLEDGMENT AND PERMISSION FORM

____

I have received the Notice of Privacy Practices and I have been provided with an opportunity to read it.

____

You (please circle one) *may* *may not* leave a message relating to my medical care on my home answering machine.

____

I give permission for you to share my medical information, including but not limited to appointment times and pathology reports, with the following people:

____

Name Relationship

____

Name Relationship

____

Name Relationship

____

Name Relationship

Patient Name:____

Date of Birth:____

Signature:____

Today's Date:____