Premier Dermatology and Skin Cancer Center

5935 Washington Ave, Ocean Springs, MS 39564
(228) 215-0669

Michele Hughes M.D, F.A.A.D Ashley Bourgeois, PA-C Lindsey Zubritsky M.D.

PATIENT INFORMATION

EMAIL ADDRESS:_____

Patient Name:_____

Patient DOB:_____ SSN:_____

GENDER: Male_____Female:_____Marital Status:_____

Patient Address: Street_____

City:_____State:_____ Zip Code:_____

Phone (Home):_____(Work)_____(Cell)_____

Preferred Language:_____Race & Ethnic Group:_____

**** If patient is under 18 years of age; Legal Guardian or Responsible Party MUST be present with valid ID****

Responsible Party's Name:_____

Address:
Street_____

City:_____ State:_____ Zip Code:_____

PREFERRED METHOD OF CONTACT: Phone_____Email_____Text_____Other_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____

TV_____Newspaper/Magazine_____Billboard_____Website_____Former Pt._____Other_____

Premier Dermatology and Skin Cancer Center
5935 Washington Ave, Ocean Springs, MS 39564
(228) 215-0669

Michele Hughes MD, F.A.A.D Ashley Bourgeois, PA-C Lindsey Zubritsky M.D.

Insurance Information

Primary Insurance

Name of Policy Holder:_____

Policy Holder's DOB:_____ SSN#_____

Policy Holder's Address:_____

Policy Holder's Employer:_____

Patient's Relationship to Policy Holder:_____

Insurance Company's Name:_____

Group Number:_____

Insured Member's ID#:_____

Secondary Insurance

Name of Policy Holder:_____

Policy Holder's DOB:_____ SSN#_____

Policy Holder's Address:_____

Policy Holder's Employer:_____

Patient's Relationship to Policy Holder:_____

Insurance Company's Name:_____

Group Number:_____

Insured Member's ID#:_____

Employer Information

Company Name:_____

Address:_____

Phone Number:_____

Premier Dermatology and Skin Cancer Center
5935 Washington Ave, Ocean Springs, MS 39564
(228) 215-0669

Michele Hughes MD, F.A.A.D Ashley Bourgeois. PA-C Lindsey Zubritsky M.D.

Financial Policy

Premier Dermatology and Skin Cancer Center is currently accepting most medical insurances. It is suggested, however, that you contact your insurance company for specific benefit questions. Most insurance companies require the patient to pay either an office visit co-pay, or a portion of their deductible.

"Co-Pays" are considered for an office visit only and generally does not include procedures. Such procedures that may require a coinsurance payment include, but not limited to, Cryosurgery ("freezing"), biopsies, and surgical removal of growths. These procedures are typically applied to the insurance deductible, therefore, would be paid based on a percentage. This amount will be determined at the time of the service and payment will be expected at the time of check-out.

Patients of Premier Dermatology will be responsible for all "Co-pays", coinsurance, and any outstanding balances at the time of check-in. For your convenience, we will accept cash, check, Mastercard, Visa, and Discover. We also office Care Credit for those patient in need of financial assistance. This option will allow our patients to create a payment plan that works best for his/her budges. Care Credit has a variety of payment plan options depending on your needs. If you are interested in applying for Care Credit, you can pick up an informative brochure in our waiting room, go online to www.carecredit.com, or call us for information on how it works.

The staff at Premier Dermatology is dedicated to providing superior service to their patients. We are committed to working with your insurance company to ensure timely billing practices on your behalf. Your cooperation in keeping the office up to date on any changes in your insurance, is greatly appreciated. If after 60 days of billing and working with your insurance company, payment has not been made, the balance will then become the responsibility of the patient.

Patients may have the option of setting up payment arrangements for large balances at the discretion of Premier Dermatology. However, if a patient fails to follow through with the payment arrangement or fails to pay an outstanding balance, Premier Dermatology will then proceed with the collections process in Justice Court. All fees incurred during the legal process will then be added to the patients balance.

Patients that are being seen for any elective procedure such as, cosmetic fillers, laser treatments, or aesthetic services, will be required to pay for those services at the time of service.

Acknowledgement of Financial Policy

I have read and understand the Financial Policy for Premier Dermatology and Skin Cancer Center. I further authorize the use of my credit card that is on file for all elective procedures that are performed at Premier Dermatology and Skin Cancer Center.

Patient Printed Name_____ Date_____

Patient Signature_____

Premier Dermatology and Skin Cancer Center
5935 Washington Ave, Ocean Springs, MS 39564
(228) 215-0669

Michele Hughes MD, F.A.A.D Ashley Bourgeois, PA-C Lindsey Zubritsky M.D.

Cancellation Policy

Premier Dermatology and Skin Cancer Center requires a 24 hour notice on all appointment cancellations. If a patient cancels his/her appointment less than 24 hours prior to his/her scheduled appointment, there will be a $50.00 cancellation fee. This fee is not payable by insurance and therefore, will be the patient's responsibility. This fee must be paid prior to, or at the patient's next appointment.

Please be considerate of other patient's waiting to be seen, and cancel if needed, in a timely manner. We understand that circumstances arise, and we will work with you on a case by case basis. However, if this becomes a recurring issue, we will not be able to continue to reconsider this fee.

Thank you for your understanding.

Patient Printed Name Date

Patient Signature

Premier Dermatology and Skin Cancer Center Staff Date

Premier Dermatology and Skin Cancer Center
5935 Washington Ave, Ocean Springs, MS 39564
(228) 215-0669

Michele Hughes MD, F.A.A.D Ashley Bourgeois, PA-C Lindsey Zubritsky M.D.

Patient Privacy Policy Acknowledgement

I have read and understand the Privacy Policy for Premier Dermatology and Skin Cancer Center. I understand that I will be given a copy of the policy if requested.

Below is a list of people that I give permission to discuss my medical care:

Name	Contact Number	Relationship
1.		
2.		
3.		
4.		
5.		

I authorize Premier Dermatology and Skin Cancer Center to release my medical records to the following physicians, insurance companies, or any other person/entity listed below"

Name	Entity
1.	
2.	
3.	
4.	
5.	

Patient Signature_____Witness_____

Emergency Contact:

Name:_____Phone Number:_____

Phone number at which it is ok to contact me:_____. You may leave a message regarding my care: Yes_____ No_____.

HISTORY AND INTAKE FORM

PAST MEDICAL HISTORY (Please circle all that apply)

Anxiety	Coronary Artery Disease	High Cholesterol
Arthritis	Depression	Thyroid Disease
Asthma	Diabetes	Leukemia
Atrial Fibrillation	End Stage Renal Disease	Lung Cancer
Bone Marrow Transplantation	GERD	Lymphoma
Breast Cancer	Hearing Loss	Prostate Cancer
Colon Cancer	Hepatitis	Radiation Treatment
COPD	High Blood Pressure	Seizures
	HIV/AIDS	Stroke

Other_____

_____

PAST SURGICAL HISTORY (Please circle all that apply)

Mechanical Valve Replacement Joint Replacement within last 2 years

Other_____

_____

REVIEW OF SYSTEMS (Please circle all that apply)

Problems with bleeding	Abdominal Pain
Problems with healing	Bloody Stool
Problems with scarring (Keloids)	Bloody Urine
Rash	Joint Aches
Immunosuppression	Muscle Weakness
Hay Fever	Neck Stiffness
Fevers or Chills (Currently)	Headaches
Night Sweats	Seizures
Unintentional Weight Loss	Depression
Thyroid Problems	Shortness of Breath
Sore Throat	Wheezing
Blurry Vision	Anxiety

ALERT (Circle all that apply)

Allergy to Adhesive

Allergy to Lidocaine

Allergy to Topical Antibiotic Ointment

Artificial Heart Valve

Artificial Joints within the last 2 years

Blood Thinners

Pacemaker

Defibrillator

History of Skin Infections – MRSA

Premedication needs prior to procedures

Rapid heartbeat with epinephrine

Pregnancy or planning pregnancy

Breast Feeding

LIST ALL ALLERGIES:

_____

_____

_____

WOMENS HEALTH (Please circle all that apply)

Urinary Incontinence

Vaginal Dryness

Loss of Vaginal Tone

Pain during Intercourse

SKIN DISEASE HISTORY (Please circle all that apply)

Acne

Actinic Keratosis

Basal Cell Skin Cancer

Blistering Sun Burns

Dry Skin

Eczema

Flaking or Itchy Scalp

Melanoma

Precancerous Moles

Psoriasis

Squamous Cell Skin Cancer

Other:_____

_____

Do you wear sunscreen? Yes No

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)?_____

_____

MEDICATIONS (Please list all current medications) _____

_____

_____

_____

FAMILY HISTORY (1st Degree Relative)

_____

_____

_____

PREFERRED PHARMACY:_____

SOCIAL HISTORY: (Circle all that apply)

Cigarette Smoking:	Alcohol Use:
Never Smoked	Never Drink
Smoke Daily	Drink Daily
Former Smoker	Socially Drink