TAREEN DERMATOLOGY
651-633-6883 tareendermatology.com
1835 COUNTY ROAD C
SUITE 250
ROSEVILLE, MN 55113

Tareen Dermatology New Patient Intake Form

Legal Name: _____ _____
(First) (Middle Initial) (Last) (Prefer to be called)

Date of Birth _____/_____/_____ Age:_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Mailing Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____ ☐ OK to leave message Cell:_____ ☐ OK to leave message

Occupation: _____ Work Phone: _____Ext: _____ ☐ OK to leave message

Email Address: _____

Emergency Contact:_____Relationship:_____Phone #:_____

Primary Care Physician and Clinic Name:_____

Minnesota State/Federal Government **REQUIRES** we ask the following question

Primary Language: ☐ English ☐ Spanish ☐ Somali ☐ Chinese ☐ Other:_____

Race: ☐ Caucasian ☐ Asian ☐ African American ☐ Other:_____

Ethnicity: ☐ Hispanic ☐ Latino ☐ Not Hispanic or Latino

Responsible Party (if different from patient)

Name:_____
(First) (Middle Initial) (Last)

Relationship to Patient: _____

Address:_____
(Street) (City) (State) (Zip)

Home Phone: ( )_____ Work: ( )_____

Date of Birth:____/____/____ Sex: ☐ Male ☐ Female

Referral (how did you hear about Tareen Dermatology)

Physician and Clinic Name: _____

Family Member: _____

Other: _____

Have you had or currently have any of the following medical conditions:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Immunosuppression
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ MRSA
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ Other:_____
- ☐ None

Are you currently: Pregnant ☐ Yes ☐ No Planning Pregnancy ☐ Yes ☐ No Breast Feeding ☐ Yes ☐ No

Have you had any surgeries? (including joint replacement and heart valve surgeries):

_____

_____

_____

Medications: (including over the counter)

_____

_____

_____

Drug Allergies:

_____

_____

Do you have or have had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma Skin Cancer
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other:_____
- ☐ None

Do you have a family history of melanoma or other skin cancers? ☐ Yes ☐ No

If yes, which relative? What type of skin cancer? _____

Smoking Status:

- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoked

Alcohol Consumption:

- ☐ None
- ☐ Socially
- ☐ Moderate
- ☐ Daily

Pharmacy Name: _____ City/State: _____

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AUTHORIZATION AND CONSENT FORM

General Release of Information & Assignment of Benefits:
I Authorize TAREEN DERMATOLOGY, P.A. on behalf of myself and/or my dependents, to furnish medical records, including films and other information related to health care services provided by TAREEN DERMATOLOGY, P.A. to Medicare, my insurance company or health management organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and file contractors and third party administrators of these parties as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled and I request payment of all such authorized benefits be made on my behalf to TAREEN DERMATOLOGY, P.A. for any services furnished by TAREEN DERMATOLOGY, P.A.

Release of Information by Payers and Networks:
I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from TAREEN DERMATOLOGY, P.A. or any other provider, with TAREEN DERMATOLOGY, P.A., other organizations in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

Payment Agreement:
I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage. If circumstances require the use of a third party collection agency, I understand that I will be responsible for payment of collections costs and/or attorney fees, if necessary.

Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers:
I authorize the release or retrieval of my medical treatment information, including films, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

Messages:
I authorize TAREEN DERMATOLOGY, P.A. to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me. TAREEN DERMATOLOGY, P.A. may call me and, if necessary, leave messages on my answering machine.

Patient Information:
By signing, I acknowledge that I have read and understood the CONSENT FOR THE GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY Form, The Financial Policy Form and the Notice of Privacy Practices (HIPAA Form) from TAREEN DERMATOLOGY, P.A.

I understand all of the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to my revocation.

_____ _____

Patient's Name (Printed) Date

_____ _____

Signature of Patient or Personal Representative Relationship to Patient (If patient is unable to sign)

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SECURE CREDIT CARD INFORMATION

Tareen Dermatology requires patients to keep a credit card, debit card or HSA card on file to pay any balance due after insurance has made payment to us (includes both primary and secondary insurance companies). This card will be used only to charge the balance due on the patient's account (co-payments, co-insurance amounts and deductibles). We will send you one invoice and await payment. If no payment is received within 59 days after the date of the invoice, we will charge your card for the balance due. Along with your credit card, we will need to take a copy of your valid photo ID.

If you do not have a credit, debit or HSA card we will need a check for $100 written out to Tareen Dermatology to be kept on file.

Itemized receipts will be mailed to you for any charges made on your card.

Your credit card information is kept on file in our HIPAA compliant electronic practice management software.

Please provide your card to the front desk staff to scan on file.

By signing this form, I authorize Tareen Dermatology to charge co-pays and any outstanding balances on my account to the credit card or check kept on file.

Print Patient Name (Printed)	Date
Patient Signature	Witness

*For patients with a financial hardship or other extenuating circumstances a payment plan can be worked out with the business office.