MEDICAL HISTORY FORM

Name_____Home Phone _____

Address _____Cell Phone _____

City_____ State _____Date of Birth _____

Zip Code_____ DL#_____ Sex __ M __ F Age _____ SS# _____

Patient's Employer_____Occupation _____

Employer's Address_____Work Phone_____

City_____ State_____Zip Code _____

Any other family members who have been treated here? __ Yes __ No Name _____

How did you find out about our practice? _____

INSURED'S INFORMATION

Name of Insured_____Date of Birth_____

Address_____ Home Phone_____

Relationship: Husband/Wife/Father/Mother/Son/Daughter _____ Occupation_____

Employer_____ Work Phone_____

Employer's Address_____

City_____ State_____Zip Code _____

IN CASE OF EMERGENCY CONTACT

Name_____ Relationship_____

Address _____ Telephone _____

Our Notice of Privacy Practices (notice) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by requested from the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We re not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this Form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as though original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

_____ _____

Signature Date

PRIMARY INSURANCE CARRIER

Name of Primary Insurance Company _____

Mailing Address for Insurance Claim _____

Name of Policy Holder _____ Relationship to policyholder _____

Name of Employer _____ Group No._____

Policy or ID No. _____ Effective Date of Policy_____

Phone Number for Verification _____

Phone Number for Pre-certification _____

SECONDARY INSURANCE CARRIER

Name of Secondary Insurance Company _____

Mailing Address for Insurance Claim _____

Name of Policy Holder _____ Relationship to policyholder _____

Name of Employer _____ Group No._____

Policy or ID No. _____ Effective Date of Policy_____

Phone Number for Verification _____

Phone Number for Pre-certification _____

KAREN A. LUND, M.D.
Payment Policy

1. We will file insurance for our PPO patients. However, all co-payment and/or deductible amounts are due at the time of the service. Any disallowed amounts are due from the patient.

2. We do not file insurance for our indemnity patients. Payment in full is expected at the time of visit and a receipt will be given for you to file with your insurance carrier.

3. There will be a thirty dollars ($30) fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited, because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount.

4. If your account has a credit balance of more than $10.00, a refund will be mailed to you within thirty (30) days.

5. **Your insurance policy is a contract between you and your insurance company**. It is important that you understand what physician services are and are not covered before seeing your doctor. **We cannot guarantee payment of your claims** by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Medicare

We accept assignment and will file insurance for our Medicare patients. However, any calendar year deductible amounts (up to the amount of the visit) are due at the time of the service. We will also file secondary insurance after payment from Medicare if we are contracted with your secondary plan. If there is no secondary insurance, the patient will be billed for any remaining balance.

Referral Authorization

Referrals must be obtained prior to the visit. If a referral is not received at the time of the visit, the patient is responsible for payment when services are rendered.

Authorization

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to Karen A. Lund, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

_____ _____

Signature Date

Please complete the following questionnaire as this will help us properly address the issues important to your health:

Please list the purpose of your visit:_____

_____

Present Health Concerns:_____

_____

1. Medical History

Do you have any of the following?	Yes	No
1. Have you ever had any skin cancer?		
2. Do you have any rashes?		
3. Any unusual skin growths?		
4. Any changes in color or size of mole?		

Are your presently receiving medical treatment for any condition(s)? ❑ Yes ❑ No

If yes please list condition(s)

Condition	How Long

2. Medications

Please list any medications you take regularly. Prescription, non-prescription, vitamins, home remedies, birth control pills, and herbs: ❑ None

Medication *(including strength)*	How many times a day	How long taken

WOMEN ONLY

Are you pregnant? _____ Menstrual periods: age at onset _____ regular? _____

Date last period began? _____

Difficulties with periods? _____ Age at menopause: _____

3. Allergies

Are you allergic to any medications? *(If yes, please list below)* ❑ Yes ❑ No

Allergic to:

4. Family History

Has any blood relative ever had:
Skin Cancer _ ❑ Yes ❑ No

HISTORY	PERSONAL yes/no	FAMILY yes/no	specify member
Anemia			
Arthritis			
Asthma			
Bladder disease			
Bleeding disorders			
Bowel disease			
Diabetes			
Eczema			
Hay fever			
Heart disease			
Hepatitis			
High blood pressure			
Hives			

HISTORY	PERSONAL yes/no	FAMILY yes/no	specify member
Intestinal disease			
Liver disease			
Melanoma			
Other skin disease			
Poor wound healing			
Psoriasis			
Scarring, unusual			
Sinus problems			
Skin cancer			
Tuberculosis			
Thyroid problems			
Ulcer - stomach			

5. Smoking

Have you ever smoked? _ ❑ Yes ❑ No

If Yes, at what age did you start? _

Do you smoke now?_ ❑ Yes ❑ No

If No, at what age did you stop? _

Fill in the appropriate columns if you ever smoked

Quantity	Present	When you stopped
Cigarettes (no./day)		
Cigars (no./day)		
Pipe (pipefuls/day)		

I, _____ give the office of Dr. Karen Lund permission to speak with the following family members, spouse, roommates, etc. regarding billing issues, lab results, or any other information pertaining to my treatment and care.

Family members, spouse, roommate, etc:

_____ _____

_____ _____

Please list the numbers you would like us to call **YOU**

Wk# _____ Can we leave a message? _____

Hm# _____ Can we leave a message? _____

Other# _____ Can we leave a message? _____

Signed _____

Date _____

THIS WILL EXPIRE IN 12 MONTHS FROM THE ABOVE DATE!!!!!!!