Mary A. Yurko M.D., Ph.D.
DERMATOLOGY

PATIENT INFORMATION

Name _____ Date of Birth _____ Sex: M F Mar. Status ____
Last Name First Name M.I.

Address _____
Street address City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Occupation:_____ Employment Status: FT PT NONE Student Status: FT PT NONE

RESPONSIBLE PARTY: (If patient is a minor)

Name _____Home Phone _____ Cell Phone_____

Address _____
Street address City State Zip Code

PRIMARY INSURANCE _____

Subscriber Name:_____Subscriber birthdate_____

Group#_____Insured's ID#_____Relation to Subscriber_____

Employer Name_____City_____ State _____

SECOND INSURANCE _____

Subscriber Name:_____ Subscriber birthdate_____

Group#_____Insured's ID#_____Relation to Subscriber_____

In case of Emergency, who should be notified:_____Phone_____

PHARMACY OF CHOICE _____ Phone _____

PRIMARY CARE PHYSICIAN _____ Did they refer you?_____

Release of Medical/Financial Information - You must give us permission to talk with others about your medical care or billing information. Unless their name is listed below, we may not speak to them about your care or your bill. Please indicate your emergency contact.

Name	Relationship	Home Phone	Mobile Phone	Medical	Billing	ER contact
				☐	☐	☐
				☐	☐	☐

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Your Privacy:

I have been informed of the Notice of Privacy Practices for Mary A. Yurko, M.D., Dermatology

_____ _____

Signature Date

Financial Policy: Patients who are covered by a private, commercial plans in which our physicians do not participate are required to pay 100% of the bill at the time of service. If covered by a plan with whom we have a contract, applicable co-payments and deductibles will be collected at the time of service, if determinable. You are responsible for paying for 100% of non-covered or cosmetic services. Payment for amounts billed to you are due within 20 daysof receiving a statement. Your signature indicates your willingness to comply with this policy.

_____ _____

Signature Date

Authorization for Payment: I authorize the release of information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I authorize payment of medical benefits directly to the physician.

_____ _____

Signature Date

Special Authorization for Medicare Patients Only:
I request that payment of authorized Medicare benefits be made on my behalf to Mary A. Yurko, M.D., Dermatology for any services furnished me by their providers. I authorize the release of information to the Centers for Medicare and Medicaid Services and its agents in order to determine benefits and payment of the claim. If "other health insurance" Is indicated I authorize releasing of the information to the insurer or agency shown. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for co-insurance and deductible amounts as directed by my Medicare carrier. (Mary A. Yurko, M.D., Dermatology is a participating provider.)

_____ _____

Signature Date

Would you like to be notified by email about cosmetic service or product specials we offer?

_____

email address

How did you hear about us? Doctor Friend Family member Yellow pages Other

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HISTORY

Date: _____
Update: _____
Update: _____

NAME _____ Date of birth: _____

TELEPHONE NUMBER to reach you with information or results _____

May we leave medical information or test results on your answering machine? _____YES _____ NO

Primary Care Physician: _____

MEDICAL HISTORY:

1. Major Illnesses/Hospitalizations/Chronic conditions _____

_____

2. Surgeries _____

_____

3. Do you have any of the following (check all that apply):

☐ Hypertension (High Blood Pressure) ☐ Diabetes ☐ Heart Disease (Murmur)
☐ Pacemaker ☐ Artificial joints ☐ Artificial Heart Valves/Stents

Explain checked items: _____

_____

MEDICATIONS: (Include creams and supplements)	Name	Dose	How often
1.			
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES TO MEDICATIONS: _____

Allergy to latex: Yes No Allergies to foods or environment? _____

Do you need to take antibiotics prior to dental or surgical procedures? Yes No

Do you smoke? Yes No How much? _____ Do you drink alcohol? Yes No How much? _____

SKIN HISTORY: (List onset, duration, any treatments)

1. General problems: _____
2. Skin cancer history: _____
3. Severe sun exposure: _____
4. Chronic X-ray treatment: _____
5. When exposed to sunlight, do you: _____ Burn _____ Burn-tan _____ Tan only

FAMILY MEDICAL HISTORY: (List any medical problems/conditions of family members)

1. Mother _____
2. Father _____
3. Children/Siblings _____

Patient Signature: _____ Date _____