ILLINOIS
DERMATOLOGY
INSTITUTE

Dear New Patient,

Thank you for choosing our practice. Please download all of the attached forms, complete them, and bring with you to your appointment.

Please bring your Photo ID and Insurance Card(s) to your initial visit. Please confirm with your insurance company that your IDI provider is in your insurance network. We have listed all of our Provider NPI (National Provider Identifier) numbers on this website under the insurance tab for your convenience.

We welcome all patients and wish to remind you to bring in a referral to your visit should your insurance plan require one. We look forward to meeting you soon!

Your IDI Skokie-Northbrook Providers

Dr. David Lorber Dr. Nona Craig Dr. Jennifer Croix

Erin Melley, PA-C Amanda Schallman, PA-C

Dr. Sara Dickie - *Plastic Surgeon*

Dr. Victoria Godinez-Puig - *Mohs Micrographic Surgeon*

Patient Name: _____ DOB: ___/___/_____ MRN (office use only):_____

Provider (Please circle): Dr. Lorber Dr. Craig Dr. Croix Dr. Godinez-Puig Erin Melley PA-C Amanda Schallman PA-C Today's Date: __/__/__

Reason for today's visit: _____

Please check all of the following boxes that apply:

Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ BPH (enlarged prostate)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Gastric Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____
- ☐ ***NO PAST MEDICAL PROBLEMS***

Past Surgeries

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Breast Reduction
- ☐ Breast: Breast Implants
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Dz
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: PTCA (angioplasty)
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Heart Transplant

Past Surgeries Continued

- ☐ Joint Replacement: Knee (Right)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Nephrectomy (Kidney Removal)
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): TURP
- ☐ Skin: Skin Biopsy
- ☐ Skin: Basal Cell Carcinoma Surgery
- ☐ Skin: Squamous Cell Carcinoma Surgery
- ☐ Skin: Melanoma Surgery
- ☐ Spleen (Splenectomy): Spleen Removal
- ☐ Testicles (Orchidectomy): Testicle Removal
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Other: _____
- ☐ ***NO PAST SURGICAL PROCEDURES***

Skin Disease History

- ☐ Acne
- ☐ Actinic Keratoses (precancers)
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous/Dysplastic Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ ***NO PAST SKIN PROBLEMS***

Skin History

Do you wear sunscreen?

- ☐ Yes. What SPF do you apply? _____
- ☐ No

Do you tan in a tanning salon?

- ☐ Yes
- ☐ No

Family History of Melanoma

Do you have a family history of Melanoma? (Not basal cell or Squamous Cell Carcinoma)

- ☐ Yes. Which relative(s)?_____
- ☐ No

Family History of Other Cancer

- ☐ Yes

  Relative_____ Type: _____

  Relative_____ Type: _____
- ☐ No

Do we have your permission to import list of medications from your pharmacy?

- ☐ Yes
- ☐ No

Have you had a Flu shot within the last 12 months

- ☐ Yes
- ☐ No

Medications: **(Please list all medications, including over the counter, supplements, etc.)**

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

☐ ***NO CURRENT MEDICATIONS***

Medication Allergies: **(Please list all allergies)**

1. _____
2. _____
3. _____

☐ ***NO KNOWN MEDICATION/DRUG ALLERGIES***

Over ⇨

Name_____MRN_____

Pneumonia Vaccine

Did you receive the Pneumovax vaccine?

- ☐ Yes
- ☐ No

Drinking Alcohol History

- ☐ No alcohol
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Smoking History

- ☐ Current every day smoker
- ☐ Current some day smoker (cigarette)
- ☐ Current some day smoker (other tobacco)
- ☐ Former smoker
  Quit smoking date: ___/___/_____
  Total years smoking: _____
- ☐ Never smoker

Review of Systems *Have you recently experienced any of the following:*

- ☐ Changing, bleeding or itching mole/lesion
- ☐ Rash
- ☐ Itching
- ☐ Burning Skin
- ☐ Fever/Chills
- ☐ Unintentional Weight Loss
- ☐ Night Sweats
- ☐ Muscle Weakness
- ☐ Joint Aches
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Blurry Vision
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Abdominal Pain/Nausea/Vomiting
- ☐ Bloody Stool
- ☐ Depression
- ☐ Hay Fever
- ☐ Problems Healing
- ☐ Burning with urination
- ☐ Heat or cold intolerance
- ☐ Frequent nose bleeds
- ☐ ***NONE***

Alerts *Important info to know about you:*

- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Artificial Joint Placed in Last 2 Years
- ☐ Artificial Heart Valve
- ☐ Antibiotic Prophylaxis
- ☐ History of Scarring (Keloid)
- ☐ History of Passing Out (Vasovagal)
- ☐ Organ Transplant Recipient
- ☐ Immunosuppressed (Low Immunity)
- ☐ Allergy to Adhesive
- ☐ Pregnant or Planning a Pregnancy
- ☐ Breast Feeding
- ☐ Stomach Upset with Antibiotics
- ☐ Yeast Infection with Antibiotics
- ☐ Allergy to topical antibiotics
- ☐ Anti-coagulated (on blood thinners)
- ☐ Allergic to Lidocaine
- ☐ Rapid heartbeat with Epinephrine
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ History of MRSA
- ☐ Problem with UV therapy
- ☐ Heart Stent
- ☐ Problem with steroids
- ☐ History of stroke
- ☐ History of heart attack
- ☐ History of atrial fibrillation
- ☐ Arrhythmia
- ☐ Latex allergy
- ☐ West Africa: Travel or Contact
- ☐ ***NONE***

Female Patients Only

Are you pregnant?

- ☐ Yes Due Date_____
- ☐ No

Are you breastfeeding?

- ☐ Yes
- ☐ No

Preferred Method of Contact

- ☐ Phone: _____
  (please circle: mobile, home, work)
- ☐ Letter
- ☐ Fax: _____

Primary Care Physician

Name: _____

Referred you to our practice? YES or NO

Phone: _____

City: _____

Hospital Affiliation: _____

Preferred Pharmacy Information

Pharmacy Name _____

City_____

Street_____

Marital status:

☐ M ☐ S ☐ D ☐ W

Preferred Language:

☐ English ☐ Spanish ☐ Other_____

Race:

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other Race:_____

Ethnic Group:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Occupation/Workplace:

_____

How did you hear about us?

- ☐ Physician: _____
- ☐ Family: _____
- ☐ Friend: _____
- ☐ Insurance Referral
- ☐ Internet search
- ☐ Other: _____

Patient/Responsible Party Signature: _____ **Date:** _____

Reviewed by (office use): _____ Date: _____

EMA Clipboard (office use): _____ ROS/Med Rec (MA initial) _____

The notice of privacy practice for Illinois Dermatology Institute, LLC office is available at the front desk and on our website at www.idi-skokie.com. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

Section 1 of this document provides your acknowledgement that you have read our Notice of Privacy Practices.

Section 2 requests your response to notification format and designation of a family member or other designee that we may contact and discuss your medical care in the event of an emergency or for the purpose of the individual items as checked below.

Section 3 provides the opportunity to opt in or opt out of receiving marketing communication from our office.

Section 1 - Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office Illinois Dermatology Institute, LLC

_____ _____

Patient Name *Date*

_____ _____

Date of Birth *MRN **(office use)***

Section 2 – Notification and Emergency Designee

I give permission to Illinois Dermatology Institute, LLC (IDI) and staff to perform the following duties in an effort to maintain continuity of care.

Confirm/revise my appointment times by calling my home, business, and any other designated phone number.

☐ **YES** ☐ **NO**

How would you like to receive your courtesy appointment reminders? (Please choose only one):

☐ **Email** _____ ☐ **Text** _____ ☐ **Phone call**_____

Leave a message of normal test results on my home answering machine or with a specified family member.

☐ **YES** ☐ **NO**

_____

The office and personnel are authorized to contact the party below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

_____

Designated Person Contact Number

Section 3 – Marketing communication.

*IDI would like to share **new product, discounts or service information directly to you**, our patient. The information may be communicated by letter, or email. (**You can change your decision at any time by notifying our office or by selecting unsubscribe on electronic communications.**)*

☐ ***I wish to opt IN*** *Email Address* _____

I understand the information provided to me in the privacy notice and I have indicated my response to questions in each section.

_____ _____

Patient Signature and Phone number *Date*

ILLINOIS
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OFFICE POLICIES

Dear Valued Patient,

Thank you for choosing our practice. Please take a moment and review our office policies to ensure that your are aware of your patient rights and responsibilities in regard to insurance, scheduling, and other important office policies.

1. It is the patient's responsibility to confirm that the provider is in-network for insurance.

2. If an insurance policy requires a referral, it is the patient's responsibility to bring the referral to the office visit. Referrals are only valid for 90 days from the issue date and are good for as many visits as the primary doctor has approved.

3. It is the patient's responsibility to know the policies of their insurance, such as copay, co-insurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc.

4. Co-pays and self-pay procedures are due at the time of service,

5. Each scheduled appointment in our office is considered an office visit and will be charged to your insurance, with the exception of suture removal appointments.

6. If a procedure is performed during an office visit, it is an additional charge to your insurance.

7. If a biopsy or excision is performed, the specimen will be sent to the laboratory and read by a Dermatopathologist. There is an additional charge for the laboratory service billed by the lab.

8. **If you need to cancel and/or reschedule an *office visit* or *surgery appointment*, please notify our office no less than 24 hours in advance. If you cancel less than 24 hours in advance or miss your appointment without notification, your account will be charged $30 for an office visit or $100 for a surgery appointment.**

9. **If you need to cancel and/or reschedule a *cosmetic procedure*, please notify our office no less than 24 hours in advance. If you cancel less than 24 hours in advance or miss your appointment without notification, your credit card on file will be charged $100.**

10. Please call our office if you will be more than 15 minutes late for your appointment. It will be up to the discretion of the provider to determine whether the appointment will need to be rescheduled.

_____

Patient Signature Date

_____

Patient Name (Printed) MRN

MRN: _____ Today's Date: ____/____/____

PATIENT INFORMATION

Name _____
Last First Middle
Mailing Address:
_____
Street City State Zip Code
***Cell phone:** ( ) _____ Home Phone: ( ) _____ Work phone: ( ) _____
(Preferred)
Email address: _____

Date of Birth: ___/____/____ Last 4 of SS#: _____ Marital status: _____ Spouse's name: _____

Age:_____ Sex: _____ Race: _____ ☐ Employed ☐ FT Student ☐ PT Student ☐ Retired ☐ Unemployed

NAME OF RESPONSIBLE PARTY (If different from patient above):

Mailing address of responsible party

_____
Street City State Zip
Cell phone: ( )_____ Home: ( )_____ Date of Birth: ___/____/___ Relationship: _____

IN CASE OF EMERGENCY, NOTIFY: _____ Phone: ( ) _____

INSURANCE INFORMATION

After completing this form, please bring it to the front desk along with your current insurance card and photo ID.

PATIENT AUTHORIZATION

I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the provider. I understand that Illinois Dermatology Institute uses photographs at times to ensure patient safety practices. I understand that Illinois Dermatology Institute does not permit taking videos, pictures, or audio recordings during any part of my care. I understand that backless chairs or chairs on wheels in the exam rooms are intended for use by providers or medical staff only.

I understand that payment is required for all services at the time they are rendered (unless I participate in an insurance plan that IDI accepts where all applicable copayments will be collected at the time of service). It is the patient's responsibility to check to see if the IDI provider is in-network. I am responsible for knowing the policies of my insurance, such as: co-pay coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc. Co-pays and self-pay procedures are due at the time of service, no exceptions. IDI accepts payment in the form of cash, credit card or check. I understand that if my check does not clear the bank, a $25 service fee will be automatically added to my account. I understand that any procedure performed in the office may be billed separately and in addition to the office visit fee and that as of January 2015, pathology is now billed separately from the path lab.

I will do my best to notify the office if I am going to be late to my appointment and understand it will be up to the discretion of the IDI provider as to whether or not I will be seen if arriving more than 30 minutes late. I also understand that I am responsible for a $30 charge for all missed appointments that I did not cancel at least 24 hours in advance. For the consideration of other patients who want to be seen, if I repeatedly cancel less than 48 hours in advance or repeatedly no show for my appointments, I understand that IDI has the right to discharge me as a patient.

My signature below signifies my understanding and willingness to comply with the above policies.

Patient or responsible party's signature: _____ Date: _____/____/____

If patient is a minor, Print name of responsible party: _____ Relationship: _____