DCA

Daniel G. Dupree, MD
Kristy Kennedy, MD
Thomas Briscoe, PA-C
Donna Vial, PA-C
Brooklyn Buras, DNP, APRN, FNP-BC

PATIENT INFORMATION

PATIENT NAME First Last M.I.		**DATE OF BIRTH**	**SEX** Female Male
ADDRESS Street		**Social Security Number**	
City State Zip	Home Phone	**Cell Phone**	Work Phone
EMAIL		Marital Status ☐ Single ☐ Widowed ☐ Divorced ☐ Married	
PREFERRED METHOD OF CONTACT ☐ Text ☐ Email ☐ Phone			
RACE ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Native American ☐ Other		ETHNICITY ☐ Hispanic ☐ Non-Hispanic	
EMPLOYER		PATIENTS OCCUPATION	
PHARMACY NAME		PHARMACY PHONE	
HOW DID YOU HEAR ABOUT US ☐ Community Event ☐ Patient/Friend/Family ☐ Employer ☐ Social Media ☐ Website or Online ☐ Insurance ☐ Magazine or Newspaper ☐ Physician ☐ Radio or Television ☐			

PERSON RESPONSIBLE FOR CHARGES

NAME	SOCIAL SECURITY NUMBER
ADDRESS Street	DATE OF BIRTH
City State Zip	CONTACT PHONE NO.
EMPLOYER	EMPLOYER PHONE NO.

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	**NAME OF REFERRING PHYSICIAN**

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	RELATIONSHIP	PHONE NO.
ADDRESS Street City State Zip		

INSURANCE INFORMATION

PRIMARY	SECONDARY
Subscriber Name:_____	Subscriber Name:_____
Insurance Name: _____	Insurance Name: _____
Policy ID #: _____	Policy ID #: _____
Group/Account #: _____	Group/Account #: _____
Subscriber DOB: _____	Subscriber DOB: _____
Relation to Patient:_____	Relation to Patient: _____

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while DCA and Daniel Dupree, MD contracts with many insurance companies, it is my responsibility to verify with my plan that DCA and Daniel Dupree, MD is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I hereby authorize DCA and Daniel Dupree, MD to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of my insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guidelines.

Patient Signature: _____ Date: _____

Privacy and Disclosure Statement

Your treatment, payment, enrollment, or eligibility for benefits at Dermatology Center of Acadiana (DCA) and Daniel G. Dupree, MD is not dependent upon whether you sign this Privacy and Disclosure statement. You have the right to revoke this Privacy and Disclosure Statement at any time by sending a written notice of revocation to DCA 1245 S. College Bldg 5, Lafayette, LA 70503, Attn: Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these and authorizations with you.

By signing below, I acknowledge that I have received the Notice of Privacy Practices of DCA and Daniel G. Dupree, MD, which explains its legal duties and privacy practices with respect to my protected health information. I understand that if I have indicated my preferred method of contact is by cell phone, I may receive text message communications regarding my scheduled appointments, appointment reminders and missed appointment notifications. I understand that standard message and data rates may apply.

I understand if I choose to opt out of receiving text message reminders, I am responsible for changing my preferred method of contact with DCA or Daniel G. Dupree, MD.

I hereby agree that DCA or Daniel G. Dupree, MD may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care, for any purpose related to my treatment or the payment of my care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient/Patient's Representative: _____ Date: _____

Printed Name of Patient/Patient's Representative: _____

Financial Policy

Dermatology Center of Acadiana ("DCA"), and Dr. Daniel G. Dupree, MD places its patients' needs first; however, we must be financially responsible to continue to serve.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at DCA and Daniel G. Dupree, MD. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that co-payments, deductibles, co-insurance, and non-covered services are paid at or before the time of service. DCA and Daniel G. Dupree, MD accepts cash, checks, major credit cards, debit cards and HSA/FSA cards.
- I understand that I may be contacted by telephone regarding my outstanding balance with DCA or Daniel G. Dupree, MD.
- I understand that if I do not have my insurance, referral, and/or co-payment, my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days, my account may be placed with an outside collection agency. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that a $35 service fee will be added for any checks returned for any reason and that I will be responsible for payment of this fee in addition to the amount of the returned check. Non-Sufficient Fund checks must be redeemed with certified funds (credit card or cash).
- I understand that I have until 4:00 p.m. the day before my appointment to cancel or reschedule. If I do not show up for my appointment and did not cancel in time, a $50 no-show fee for medical visits or a $100 no-show fee for surgical, cosmetic or hormone appointments will be charged to my account.
- I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

Statement of Financial Responsibility: I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Patient Name: _____ Patient DOB: _____

PATIENT PAST MEDICAL HISTORY

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Other:
- ☐ None

PAST SURGICAL HISTORY

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removed
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Removed)
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None
- ☐ Other_____
- ☐
- ☐
- ☐
- ☐
- ☐

SKIN DISEASE HISTORY

Circle all that apply:

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering
Dry Skin
Eczema
Flaking or Itching Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other:_____

Do you wear Sunscreen? Yes No
If yes, what SPF?_____
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 medications you are currently taking below: ☐ None

Patient Name: _____ Patient DOB: _____

KNOWN DRUG ALLERGIES/ALERTS

Check all that apply:

☐ Latex	☐ Artificial Heart Valve	☐ MRSA	☐ Rapid Heartbeat w/ Epi Other
☐ Adhesive	☐ Artificial Joint Replacement	☐ Pacemaker	☐ None
☐ Lidocaine	☐ Blood Thinners	☐ Pregnant	☐
☐ Topical Antibiotics	☐ Defibrillator	☐ Require Antibiotics Prior to Surgery	

SOCIAL HISTORY

Tobacco: ☐ No ☐ Yes How many packs per day? _____ How many years? _____ ☐ Quit _____ yrs ago

Alcohol: ☐ No ☐ Yes How much do you drink daily? _____ ☐ Quit _____ yrs ago

PAST FAMILY MEDICAL HISTORY

Conditions related to immediate family only:

PHARMACY

Please list where you would like to send your prescription:

Pharmacy Name: _____

City: _____ Zip: _____ Phone Number: _____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following? ☐ check here if unknown

STMPTOM	Yes	No	STMPTOM	Yes	No	STMPTOM	Yes	No
Problems with bleeding	☐	☐	Thyroid problems	☐	☐	Cough	☐	☐
Problems with healing	☐	☐	Sore throat	☐	☐	Shortness of breath	☐	☐
Problems with scarring	☐	☐	Blurry vision	☐	☐	Wheezing	☐	☐
Rash	☐	☐	Abdominal pain	☐	☐	Anxiety	☐	☐
Immunosuppression	☐	☐	Bloody stool	☐	☐	Depression	☐	☐
Hay fever	☐	☐	Joint pain	☐	☐			
Chest pain	☐	☐	Muscle weakness	☐	☐			
Fever or chills	☐	☐	Neck stiffness	☐	☐			
Night sweats	☐	☐	Headache	☐	☐			
Unintentional wt loss	☐	☐	Seizure	☐	☐			