PATIENT REGISTRATION FORM

Patient Information

First Name | Middle Initial | Last Name

Preferred Name | Date Of Birth | Gender

Address | Apt # | City | State

Zip Code | Home Phone | Cell Phone

Email

Preferred Method of Contact Home Phone ☐ Cell Phone ☐ Text Message ☐ Email ☐

Primary Care Provider | Referring Provider

Guarantor Information (For Minors, Patients Over 18 Will Be Considered Their Own Guarantor)

First Name | Middle Initial | Last Name

Date Of Birth | Relationship to Patient

Address | Apt # | City | State

Zip Code | Home Phone | Cell Phone

Email

Insurance Information

Primary Insurance | Policy ID # | Group #

Eff. Date | Insured's Name | Insured's Birthdate

Secondary Insurance | Policy ID # | Group #

Eff. Date | Insured's Name | Insured's Birthdate

In Case Of Emergency

Emergency Contact Name | Relationship

Home Phone | Cell Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or insurance company to release any information required to process my claim.

Patient / Guardian Signature Date

PATIENT REGISTRATION FORM

_____
Initials

CONSENT FOR TREATMENT: I authorize this office and its personnel to provide ongoing medical care, treatment and procedures (skin biopsies, routine surgical procedures, etc.) as ordered by the physicians and/or other healthcare professionals. Some tissue and cultures are sent to outside laboratories. If your insurance carrier requires a specific facility, please let our team know at the time service is rendered. I acknowledge that no guarantee can or will be made as the results of the care, treatment and medication prescribed.

_____
Initials

CONSENT FOR RELEASE OF INFORMATION: I authorize this office to release to my insurance carrier(s) including Medicare, Medicaid and any other reimbursing agency information about my identity, treatment, diagnosis, prognosis and/or services rendered as permitted by state and federal law which may be required or requested, thus releasing this office from any liability for furnishing such information. Information may also be sent to other physicians involved in your care. I understand information may be released through electronic or paper media.

_____
Initials

NOTICE OF HEALTH INFORMATION PRACTICES: I acknowledge that the Notice of this office's Privacy Policy is on file and I may access it at any time.

_____
Initials

ELECTRONIC CONSENT: I agree to receive communication via email or text message regarding my appointment.

_____
Initials

UNACCOMPANIED MINORS: After the initial visit, I authorize this office and its personnel to provide any healthcare deemed necessary for the treatment and/or diagnosis of my child as follows:

☐ Without any adult present.

☐ With the following adult(s) present, who may consent to the treatment of my child and may receive health information related to my child:

Name	DOB	Relationship
_____	_____	_____
_____	_____	_____

☐ My child may NOT receive care in my absence. I will accompany my child to all visits.

_____ _____

Patient / Guardian Signature Date

HEALTH HISTORY FORM

☐ New Patient ☐ Annual Update	Last Name	First Name	MI	Date Of Birth
Primary Reason For Today's Visit?				Date
Additional Details				

Medical History Review of Systems

Please circle all conditions that apply. Check "No" if none apply.

System Review	Circle all that apply (presently)	No	Comments
Constitutional	Fevers, chills, night sweats	☐	
Skin	Color changes, infections, masses, open sores, hair changes, rash, itching, eczema	☐	
Ears, Nose, Throat	Loss of hearing, trouble swallowing, nosebleeds, hoarseness,earache, nasal polyps, ear ringing	☐	
Eyes	Visual loss or change, trauma, contacts, cataracts, blurred vision, glaucoma	☐	
Respiratory	Shortness of breath, asthma, difficulty breathing, emphysema,bronchitis, tuberculosis	☐	
Cardiovascular	Heart attack, irregular heartbeat, heart murmur, chest pain, high blood pressure	☐	
Gastrointestinal	Ulcer, hepatitis, weight changes, bowel changes, weight gain, weight loss, liver problems, intestinal disorders, reflux	☐	
Genitourinary	Painful urination, difficulty urinating, blood in urine, renal disease/failure, frequent urination, kidney problems	☐	
Musculoskeletal	Arthritis, weakness, back pain, joint pain, cramps, stiffness, osteoporosis	☐	
Neurologic	Seizures, stroke, balance changes, numbness/tingling, headaches, dizziness, migraines, myasthenia gravis	☐	
Psychological	Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression, mental disorders, nervousness	☐	
Endocrinology	Intolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue, diabetic	☐	
Hematologic	Blood clots, anemia, bleeding problems, hepatitis, blood transfusions, platelet disorder	☐	
Immunologic/Allergic	Dermatitis, latex allergy, hives, rash, asthma, hay fever, diabetes	☐	
Other Medical Problems	Such as: Cancers, infectious disease, HIV, autoimmune disease, etc.	☐	

Current Medical Conditions (Check Any That Apply)						
Hepatitis ☐	Leukemia ☐	Cancer ☐ Type:	Last Hemogloin A1c:		Kidney Disease ☐	HIV/Aids ☐
Anxiety ☐	Diabetes ☐	Lymphoma ☐	Atrial Fibrillation ☐	Hypertension ☐	Strokes ☐	Seizures ☐

Past Surgeries (Check Any That Apply)						
Appendix ☐	Breast ☐	Heart ☐	Gallbladder ☐	Liver ☐	Skin: Squamous Cell ☐	Skin: Melanoma ☐
Bladder ☐	Colon ☐	Joint ☐	Kidney ☐	Prostate ☐	Skin: Basal Cell ☐	
Additional Surgery Details:						

Skin History

Skin Cancer		
Have You Ever Had Skin Cancer? ☐ Yes ☐ No	What Type?	When?

HEALTH HISTORY FORM

Other Skin Conditions (Check Any That Apply)					
Acne ☐	Eczema ☐	Poison Ivy ☐	Rosacea ☐	Hay Fever/Allergies ☐	Actinic Keratosis ☐
Dry Skin ☐	Psoriasis ☐	Blistering Sunburns ☐	Flaking or Itchy Scalp ☐	Precancerous Moles ☐	
Other(s):					
Additional Skin History Details:					

Sun Exposure History	
Do you use sunscreen? If no, why? ☐ Daily ☐ Sometimes ☐ Only Outside ☐ No	
What SPF Do You Use?	What is Your Favorite Sunscreen?
Do you use an indoor tanning bed? ☐ Current ☐ Past ☐ No	

Family History - Skin Cancer	
Do You Have a Family History of Skin Cancer? ☐ Yes ☐ No	Which Relatives?
Do You Have a Family History of Melanoma? ☐ Yes ☐ No	Which Relatives?

Medications and Allergies																			
Current Medications: _____ Please initial if you give us permission to access your medication records from your pharmacy.																			
Blood Thinners: ☐ Yes ☐ No		Aspirin		Coumadin		Plavix		Xarelto		Pradaxa		Vitamin E		Fish Oil		Garlic			
Drug Allergies:																			
Any Other Details We Should Know:																			

Additional Questions														
Smoking Status (Choose One) ☐ Every Day ☐ Sometimes ☐ Former ☐ Never ☐ Unknown						Do You Drink Alcohol? (Choose One) ☐ Yes ☐ No		Drinks Per Day _____						
Are You Planning On Getting Pregnant? ☐ Yes ☐ No						Is Your Menstrual Cycle Regular? ☐ Yes ☐ No								
Have You Ever Taken Accutane? ☐ Yes ☐ No				How Long?				When?						
Have You Had Your Pneumonia Vaccine? ☐ Yes ☐ No				Do You Have a Health Care Proxy? ☐ Yes ☐ No				Do You Have a Living Will? ☐ Yes ☐ No						
Any Additional Pertinent Medical History For Immediate Family Members?														

Patient Signature: _____ **Date:** _____

The health care provider signature below indicates this entire form was reviewed to include:
past medical history · family history · social history · surgical history · review of systems

Provider Signature: _____ **Date:** _____

FINANCIAL POLICY FORM

Welcome and thank you for choosing us for your dermatologic care. We are committed to providing you with the highest quality care in an efficient, timely and cost-effective manner. Please take a moment to review our financial policy so you understand your responsibility regarding the charges for the services rendered to you by this office.

Insurance: Before getting care from one of our providers, it is your responsibility to confirm with your insurance plan if our providers are in or out of network.

Patient Balance (co-payment, deductible and co-insurance): You are responsible for any portion of your charges remaining unpaid by your insurance company, this includes non-covered services, co-insurance, co-payments and deductibles. We accept credit cards, checks or cash. A $35 fee will be assessed on returned checks. All co-payments are due at time of service. If the deductible and/or co-insurance is known at the time of your procedure(s), a 50% deposit of the estimate owed by you will be requested.

Referrals: If your insurance company requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain one. If the referral is not sent to us prior to your scheduled appointment, you may be asked to reschedule the visit. It is also your responsibility to ensure your PCP is listed correctly with your insurance company. If the PCP is not correct at the time of service, you will be responsible for full payment.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the clinician and complete all necessary paperwork. A signed authorization from the parent or guardian allowing our clinician to provide medical treatment is available for subsequent visits.

Determining Guarantor: The guarantor is the responsible party held accountable for this patient's bill. The guarantor is always the patient if over the age of 18. The guarantor for a minor child is the parent who presents the child for care at the time of the initial visit.

Non-Payment: If your account is 90 days past due, we will refer your account to an external collection agency. The collection vendor may report your delinquency to a credit bureau and may file litigation in efforts to collect the total balance due. Any litigation fees will be applied to the collection balance.

Medical Necessity: If your insurance policy denies any procedure as NOT MEDICALLY NECESSARY, you are responsible for payment in full.

Missed Appointments: If you are unable to keep your appointment, please notify our office at least two business days in advance. Failure to provide notice and/or excessive missed appointments could result in additional fees or dismissal from the practice.

Patients Without Insurance (Self-Pay): Full payment is due at the time of service. You may request a reasonable estimate of your services prior to arrival. This estimate will be based on known diagnosis at the time of scheduling, but **your charges are subject to changes based on actual services rendered**. A good faith estimate will be provided at time of service. Please note: if you have a procedure, your specimen may be sent out for tissue processing which could generate additional fees from the laboratory/pathologist and will not be included in the estimate.

Medicare Payment Policy: We are participating providers of the Medicare program. We will accept assignment on all claims. You are responsible for meeting your annual deductible and paying for the 20% co-insurance. We do file with secondary supplemental carriers. However, in the event the secondary does not pay, you will be responsible for the remaining balance.

Cosmetic Procedures & Cosmetic Products: Payment in full for cosmetic procedures and products is required at your visit and is non-refundable. Cosmetic procedures including (but not limited to) skin tag removal, varicose veins, Botox, fillers, laser surgery, hair removal, photorejuvenation, chemical peels, and microdermabrasion treatments are not covered by insurance and claims will not be filed for them. If there is a medical balance due at the time you check in for a cosmetic service, the balance must be paid in full before you can be seen for the cosmetic service. We do not accept checks for cosmetic procedures or products.

Credit Card on File: You have the option to put a credit card on file to process any balances after insurance has paid. Please notify the front desk if you would like to place a credit card on file. Your payment will be processed once the insurance company has processed the claim and a statement has been sent. The credit card will be processed two weeks after statement has been mailed.

Assignment of Benefits: With your signature below, you are agreeing to give the practice all rights, title and interests to reimbursement in accordance with the terms of your insurance policy or other health benefit. You are also agreeing to the financial policy as stated above.

I have read, understand and agree to the above financial policy. I understand my financial responsibility to make payments for services provided to me.

Patient/Guarantor Printed Name _____

Patient/Guarantor Signature _____ **Date** _____