Advanced Dermatology & Skin Care Centre's Registration Form

Welcome to our office!

PATIENT INFORMATION:

Patient Name (First, MI, Last): _____ Gender: □ *Male* □ *Female*

Street Address: _____ Home Phone: _____

City, State, Zip code: _____ Work Phone: _____

Marital status: □ *Single* □ *Married* □ *Other* Cell Phone: _____

Birth Date (Mo/Date/Year): _____ Age: _____ E-mail: _____

Preferred Method of Contact: □ Home Phone □ Work Phone □ Cell Phone □ E-mail □ Other: _____

Who is your Primary Care Physician: _____ Clinic Name: _____

What is the name and location of your preferred Pharmacy? _____

Currently employed? □ **Yes** □ **No**

If "yes" then complete: Name of employer: _____ Occupation: _____

Race: □ African-American □ Asian □ Caucasian □ Hispanic □ Other: _____

Primary Language: □ English □ French □ Spanish □ Other:_____

Is the Patient a Minor? □ **Yes** □ **No**

If "yes" then complete: Legal Guardian/Parent Name (First, Last) _____

Phone (if different than above): _____

EMERGENCY CONTACT INFORMATION:

Name (First, Last):_____

Relationship to Patient: □ Spouse □ Parent / Guardian □ Friend □ Other: _____

Home Phone of Emergency Contact: _____ Work Phone of Emergency Contact: _____

INSURANCE INFORMATION:

Insurance Carrier: _____ Policy #: _____ Group #:_____

If your insurance is Tricare, then which type: □ Tricare Prime □ Tricare Standard □ Tricare-for-Life

If Tricare, what is the Holder's Social Security Number: _____

Policy Holder's Name: _____ Holder's date of birth (Mo/Day/Year): _____

Holder's Gender: □ *Male* □ *Female* Patient's relationship to Holder: □ Self □ Spouse □ Child □ Other

Does the patient have a secondary insurance? □ **Yes** □ **No**

If "yes" then complete: Secondary Health Insurance: _____ Policy #: _____

HOW DID YOU HEAR ABOUT US?

□ Primary Care Physician □ Other Provider (Name: _____) □ Insurance Plan □ Family Member

□ Friend □ Internet □ TV advertising □ Newspaper/Magazine □ Other: _____

Were you medically referred to dermatology and/or our clinic? □ **Yes** □ **No**

If "yes" then who referred you: □ Primary Care Physician □ Other Physician (Name: _____)

Dermatology Medical History – New Patient

NAME (LAST, FIRST): _____ **Date of Birth** (MM/DD/YY): _____ **Today's Date:** _____

Race: □African-American □Asian □Caucasian □ Hispanic □Other: _____ **Primary Language:** □English □Other:_____

REASON FOR VISIT: _____

MEDICAL HISTORY:

Are you allergic to any medications? □ **YES** □ **NO** If "YES," list allergies: _____

Have you ever had dental anesthesia (such as Novocain)? □ **YES** □ **NO** Any bad reactions to anesthesia? □ **YES** □ **NO**

MEDICATIONS:

List all medications currently taking (including prescription, over-the-counter meds, vitamins and herbals): _____

_____

Do you have now, or ever had any of the following: (Please check **YES** or **NO**):

	YES	NO
Prescribed Blood Thinner	□	□
Bronchitis	□	□
Emphysema	□	□
Asthma	□	□
Chronic cough	□	□
High blood pressure	□	□
Heart Attack	□	□
Irregular heartbeat	□	□
Blood clots	□	□
Pacemaker/Defibrillator	□	□

Other Systems:	YES	NO
Diabetes	□	□
Thyroid disorder	□	□
Kidney disease/ dialysis	□	□
Bladder problems	□	□
Hepatitis or Infectious Disease	□	□
Arthritis/Joint deformity	□	□
Artificial joint	□	□
Convulsions/Seizures/Epilepsy	□	□
Lupus or Autoimmune Disorder	□	□

- List any other disease or condition not listed above: _____
- List any surgical procedures in the past 6 months: _____

FAMILY HISTORY: Any Family History of:

	YES	NO	If "yes," who?
Autoimmune disorders	□	□	_____
Diabetes	□	□	_____
Heart disease	□	□	_____
High blood pressure	□	□	_____
Melanoma	□	□	_____
Skin cancer (not melanoma)	□	□	_____
Any other skin disease	□	□	_____

YOUR SOCIAL HISTORY:

Alcohol use? □ **YES** □ **NO** If "yes," how much? _____

Any IV or illegal drug use? □ **YES** □ **NO** If "yes," explain: _____

Exposure to HIV (AIDS)? □ **YES** □ **NO** If "yes," explain: _____

Sexually transmitted disease? □ **YES** □ **NO** If "yes," explain: _____

TOBACCO HISTORY:

Use any tobacco? □ **NO** □ **YES** □ **QUIT** How do you or did you use? _____

If you quit, how long ago? _____

YOUR SKIN HISTORY:

Have you ever had skin cancer? □ **YES** □ **NO**

Do you have a history of any specific skin disease? □ **YES** □ **NO**

Do you have problems while healing? □ **YES** □ **NO**

Do you develop keloids (thickened scars) after surgery? □ **YES** □ **NO**

Do you bleed easily? □ **YES** □ **NO**

Do you develop skin rashes in reaction to: □Medications □Food □Environment □Bandages □Topical Neosporin □Other: _____

REVIEW OF SYSTEMS:

	YES	NO
Allergy/Immunologic:		
Seasonal allergies	□	□
Runny nose/itchy eyes	□	□
Cardiovascular:		
Palpitations / Chest pain	□	□
Constitutional/Symptom		
Fever / Chills	□	□
Nausea / Vomiting	□	□
Endocrine		
Cold/heat intolerance	□	□
Low energy/tired	□	□
Ear, Nose, Throat & Mouth		
Swallowing problems	□	□
Mouth sores or cold sores	□	□
Eyes		
Vision problem/itchy eyes	□	□
Gastrointestinal (GI):		
Diarrhea/Constipation	□	□
Unplanned weight loss	□	□
Genitourinary (GU):		
Blood in urine	□	□
Burning with urination	□	□
Hematologic/Lymphatic:		
Enlarged glands or nodes	□	□
Musculoskeletal:		
Muscle aches / arthritis	□	□
Neurological:		
Memory loss / headaches	□	□
Psychiatric:		
Depression/Mood swings	□	□
Anxiety	□	□
Respiratory:		
Difficulty breathing	□	□
Wheezing/Short of Breath	□	□
Skin Condition(s):		
Rash	□	□
Non-healing lesion	□	□

PREFERRED PRIMARY METHOD OF CONTACT:

□ Cell □ Home Phone □ Work Phone □ Pager □ Email □ Mail

What is your occupation? _____

Women ONLY section:

Are you pregnant now? □ **YES** □ **NO**

If "yes," what is the due date: _____

Are you breastfeeding? □ **YES** □ **NO**

FORM COMPLETED BY: □ Patient □ Guardian □ Other: _____

RELEASE OF INFORMATION, CONSENT FOR CARE & PATIENT RESPONSIBILITIES

RELEASE OF MEDICAL INFORMATION

I, the undersigned as the patient, _____, or his/her authorized representative/guardian, do hereby authorize Advanced Dermatology and Skin Care Centre (hereby referred to as Advanced Dermatology) to release my insurance company/companies or other appropriate agency/agencies that information which is necessary to validate this claim. Advanced Dermatology is also hereby authorized to release to my physician(s), either as an individual(s) or as a professional association, who perform service for me, the patient, on a fee for service basis such information to physicians other than original referring physicians, who may be involved in my or my child's health care treatment, when requested by these physicians. By signing this consent, information will be given to requesting physician(s) without further signed authorization. I hereby give permission to disclose personal medical information about my treatment to the individuals indicated the section below.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY

I do hereby authorize payment of all insurance benefits, basic and major medical for these services, to be made directly to Advanced Dermatology. I understand that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees.

STATEMENT TO PERMIT OR MEDICARE BENEFITS TO PROVIDER PHYSICIANS AND PATIENT

I request that payment of authorized Medicare or other applicable private insurance benefits be paid directly to Advanced Dermatology for services provided under their care. I also authorize Advanced Dermatology to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

CONSENT FOR MEDICAL SERVICES

I authorize Advanced Dermatology to render treatment to me/my dependents for dermatological care/medical procedures as may be deemed necessary.

DIGITAL PHOTOGRAPHY

I authorize the physicians/staff of Advanced Dermatology to take digital photographs that relate to my care. Advanced Dermatology will only disclose information relevant to current treatment. I authorize the photos to be used for medical care/evaluation, medical training/education and medical-related publications. To the maximum extent, my identity and identifiable features shall be protected.

RESPONSIBILITY FOR MEDICAL SERVICES

I understand that Advanced Dermatology does not assume responsibility for personal property.

REFERRALS/AUTHORIZATIONS

I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of service.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

A copy of Advanced Dermatology's Notice of Privacy Policies may be requested detailing how my information may be used and disclosed as permitted under federal and state law.

MISSED APPOINTMENTS

Our office requires a 24-hour notice for cancellations. Failure to do so may result in a $30 fee for medical appointments and $50 for cosmetic procedures.

SUMMARY OF VISIT

I understand I may obtain a summary of an appointment, which shall be provided no later than three (3) business days after the request.

May we leave personal medical information on your answering machine at home/cell phone? □ **Yes** □ **No**

_____	_____	_____	_____
Signature of Patient/Guardian	Date	Witness Signature	Date