PATIENT REGISTRATION FORM

Name _____ Today's date _____
Last First M.I.

Mailing Address _____Birth Date _____
Number, Street, Apartment Number

_____
City State Zip

Home Phone (____)_____ Work Phone (_____)_____ Cell Phone (_____) _____

Email Address _____ Marital Status _____ Gender _____

Employer_____ Retired ____ Full Time Student ____ Part Time Student ____

Spouse's Name: _____ Employer _____ Work # _____

Person to notify in case of emergency _____ Phone _____
(Please list a person not living in your home)

Referring Doctor _____

May we leave a message on your home answering machine? □Y □N
May we leave a message for you at work to call us? □Y □N
May we discuss your medical condition with another person? □Y □N

If yes, whom _____ Relationship _____Phone # _____

Would you like to periodically receive information about our cosmetic services, products, and specials? □Y□N

How did you hear about our practice? □Insurance Plan □Hospital □Family □Friend _____ □Internet
□Advertisement □Yellow Pages □Other _____
****
Policy Holder (if different from patient or responsible party) _____

Policy Holder's Date of Birth ____/___/_____ Employer of Policy Holder _____

Work Phone(____)_____ Patient's Relationship to Policy Holder _____

****
If patient is a minor please enter responsible party information. (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Name _____
Last First M.I.

Address _____
Number, Street, Apartment Number

_____
City State Zip

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____
****

PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST

We ask our patients to be aware that as of this time, we are participating only with Medicare and Cigna. The other insurance companies with whom we intend to contract have not yet finished their part of the process. We may copy your card today for future use, but you may be responsible for your visit today.

ASSIGNMENTS OF BENEFITS

ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to _____. I authorize the practice to provide to my insurance company, any information necessary to process claims for services rendered to me.

_____ _____

Signature as it appears on your insurance card Date

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare Card Date

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be paid on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier _____ any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on MEDIGAP Card Date

☐Y ☐N Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job?

☐Y ☐N Are you covered by any other insurance that Makes Medicare secondary?

Patient History and Intake Form

Name _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Past Surgical History: (please circle all that apply)

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)
Other _____
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Name _____

Skin Disease History: (please circle all that apply)

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

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Medications: (Please enter all current medications)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:
- None
- less than 1 drink per day
-1-2 drinks per day
-3 or more drinks per day

Other_____
Family History (Only first degree relatives, mother, father, brother, sister, child)

Non-melanoma skin cancer	Yes	No	Which relative(s)? _____
Psoriasis	Yes	No	Which relative(s)? _____
Eczema	Yes	No	Which relative(s)? _____
Melanoma	Yes	No	Which relative(s)? _____

Name _____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Allergies to latex		
Asthma		
Bleeding Disorder		
Blood Clots		
Dizziness		
Headaches		
Joint Pain		
Shortness of Breath		
Skin Rash		

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine (Local Anesthesia)
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to become pregnant?

Name _____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Thank you for choosing Dermatology Boutique for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____
Signature of Patient/Legal Representative)

_____
Date

_____ _____ _____
Signature of Staff Member Title Date

Comments: