Family Dermatology Co.

Patient Registration Packet

Patient Name & Info Today's Date: _____

First:	Middle initial:	Last:	
Date of Birth:	Social Security #:		Gender: Male or Female
Race:	Ethnicity:	Language:	
Marital Status: Single Married Divorced Widowed Separated Other:			

Contact Information

Best Phone (primary): _____ May we leave a detailed message at this number? **YES NO**	Alternate Phone: _____ May we leave a detailed message at this number? **YES NO**
Email Address:	

Emergency Contact Name:	**Phone:**
Relationship to Patient:	

Mailing Address

(Please provide the mailing address for correspondence)

Street Address or PO Box:		Apartment # (If any):
City:	State:	Zip:

Insurance Information

Please complete all information even though it may be printed on your insurance card.		
Primary Insurance	Subscriber/Member ID:	Patient relationship to subscriber:
Secondary Insurance	Subscriber/Member ID:	Patient relationship to subscriber:

Name of primary care provider: _____

Referring provider: _____

Preferred pharmacy: _____

Phone number: _____

If possible, do we have your permission to import your medications from your pharmacy into our electronic medical records system? **YES NO**

With whom may we discuss your medical condition/information with?

Name: _____

Relationship to patient: _____

Missed Appointments/Cancellation Policy

First and foremost, we would like to thank you for being a patient in our office!

We value all of our patients and strive to provide the best care possible. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.

We kindly ask that if you must change an appointment, or if you are unable to keep an appointment, please call as soon as you can and **please give at least 24 hours' notice**. This courtesy makes it possible to give your reserved time to another patient who would like it.

If an appointment is not cancelled or rescheduled at least 24 hours in advance, you may be charged a $25 fee for phototherapy appointments, a $50 fee for regular appointments, and a $250 fee for surgery appointments. **These fees will not be covered by your insurance company**.

By signing, you are agreeing that you acknowledge and understand the above information.

Patient or responsible party signature: _____

Date: _____

Family Dermatology Co.

Financial Policy

For billing questions, please call: 855-298-6837

Thank you for taking the time to read our financial policy.

If you are self-pay (no insurance) or are here for a cosmetic appointment, your balance is due at the time of service. Co-pays required by your insurance policy are also due at the time of service.

We bill your insurance as a courtesy to you, but you are ultimately responsible for payment. You are also responsible for understanding how your insurance works. If your insurance denies a claim due to inaccurate or incomplete information you provided to either us or them, we may bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance company before seeking payment from you. We will help you as best we can to get proper and timely payment from your insurance company.

If we do not have a contract with your insurance carrier, then the total financial responsibility is determined by our prices for the services rendered.

Please pay your bill promptly by calling our billing company at your earliest convenience. Balances extremely past due may be subject to collections. In all cases, our billing company will attempt to contact you as a courtesy before these measures are taken.

***** We ask that you please provide us with the most current insurance you have. You are responsible for any charges you may receive due to not updating our office with any insurance changes. It is your responsibility to update us with any changes made throughout the year.**

My signature below indicates that I understand and agree to this financial policy.

Patient or responsible party signature: _____

Date: _____

Today's Date: _____ Date of Birth: _____
Patient Name: (First, middle, and last) _____

Past Medical History: (Please circle and list all that apply) ……..**NONE**

Anxiety	Elevated Blood Pressure	Hypercholesterolemia
Arthritis	End-stage Renal Disease	Hyperthyroidism
Asthma	Epilepsy	Hypothyroidism
Atrial Fibrillation	GERD	Leukemia
Depression	Hypertension	Malignant Lymphoma
Diabetes	HIV	Malignant Tumor

_____

_____

Past Surgical History: (Please circle and list all that apply) ……..**NONE**

Appendix Removal Hysterectomy Hip Replacement (Left, Right, Bilateral)
Bone Marrow Transplant Kidney Transplant
Heart Valve Replacement Knee Replacement (Left, Right, Bilateral)

_____

_____

Skin History: (Please circle and list all that apply) ……**NONE**

Acne	Eczema	Psoriasis
Actinic Keratosis	Hay Fever	Squamous Cell Carcinoma
Basal Cell Carcinoma	Melanoma	Sunburn

_____

_____

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? _____

Medication Allergies: (Please list all allergies to medications)

Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

Other allergies: _____

Medications: Please enter all current prescription and over-the-counter medications including supplements. You may also provide a list if you have one available.

Name of medication:	Strength: (Ex: mg, mcg, ml)	Route: (oral, tablet, capsule, topical)	How often: (How many times a day?)	Approximate date you started this medication:

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently smokes
Never smoked
Former smoker – Quit __ months/years ago

Alcohol Use:

None
Less than one drink per day
1-2 drinks per day

Review of Systems: Are you currently experiencing any of the following?

	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Immunosuppression		
Changing mole		
Rash		

Other symptoms: _____

Alerts: (Please circle all that apply)

Pacemaker
Defibrillator
Artificial joints within the past two years
Artificial heart valve
Premedication prior to procedures
Allergy to adhesive
Allergy to topical antibiotics ointments
Blood thinners
Pregnancy or planning a pregnancy
Allergy to lidocaine
Latex allergy
Rapid heartbeat with epinephrine
Yeast infections with antibiotics
GI upset with antibiotics
Hepatitis A, Hep B, or Hep C
HIV

Patient or responsible party signature: _____

Date signed: _____ **Page 5 of 5**