The Dermatology Center

Patient Registration Form

Patients Personal Information

Name:_____ Date of Birth:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Place of Employment _____

Preferred number to be contacted for reminders and path results:_____

SS#:_____Email:_____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Race:_____

Responsible Party/Policyholders Information ☐ Info same as above

Name:_____Date of Birth:_____

Relationship to patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other_____

Address:_____

City:_____ State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Place of Employment _____

SS#:_____Email:_____

Insurance Information

Primary Insurance:_____

Policy Holders Name:_____Date of Birth:_____

Secondary Insurance:_____

Policy Holders Name:_____Date of Birth:_____

How did you hear about us? ☐ Phone Book ☐ News Paper ☐ Website ☐ Radio ☐ Event ☐ Other

(Please explain)_____

Are there any cosmetic services you would like to learn more about? ☐ Yes ☐ No

(if yes, what are you interested in?)_____

***Would you like to receive email notifications on MedSpa Events & Specials? ☐ Yes ☐ No**

The Dermatology Center
Financial Policy

Insurance information: We will bill your insurance company if we participate with that company. Participation with insurance means that we have a contract with that insurance company. **You are responsible for presenting your current insurance card at each visit**. By giving us your insurance information you are authorizing all insurance payments to go directly to The Dermatology Center. Our contract with your insurance company requires that we collect your co-pay at the time of service. We will also collect any outstanding balance when you check in. You are responsible for any and all charges that your insurance company does not cover such as deductibles, co-copays, co-insurance and non-covered services. Please call your insurance company to verify participation. **If we do not participate with your insurance company or you do not bring your insurance card** you will be required to pay the bill in full at time of service. _____ **Initial**

Patient Responsibility: I understand that I am responsible for any amount not covered by insurance. I agree to provide payment within 30 days of receiving notification that the balance is my responsibility. We accept Cash, Checks, Visa, Mastercard, American Express, Discover and CareCredit. If the account is not paid in 30 days a $5 processing will be added to each billing cycle until account paid in full. If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, will be added to the balance. If your account is placed with a collection agency, you will be dismissed from the practice and will have 30 days to transfer your care to another physician._____ **Initial**

Returned Check fee: A $50 processing fee will be charged for returned checks. That amount must be paid in cash or by credit card prior to making another appointment. _____**Initial**

No Call No Show fee/Missed Appointment fee: Any appointment that is not cancelled **24 hours** prior to your appointment will be charged $50 for a medical appointment and $150 for surgical appointments. If you are late and it results in the appointment being rescheduled there will be a $50 charge for the missed appointment. This balance must be paid prior to making another appointment. _____**Initial**
We make courtesy reminder calls two(2) days prior to appointments. This is a courtesy reminder. For any reason you do not receive your reminder, **this does not negate the no show policy. It is your responsibility to remember your appointment day and time.

Treatment of Minors: Any minor (under age 18) who is treated at The Dermatology Center **MUST have a parent/legal guardian present with them for <u>ALL</u> appointments.** Any minor that is scheduled to have a **surgical procedure MUST** have a parent/legal guardian present with them. I certify that I understand the above and will adhere to this policy. _____**Initial**

Pathology and Lab Charges: If you have any lesions removed, the specimen will be sent to an outside lab. We will send them your insurance information. We do not have access to their billing so any questions or balances due will need to be addressed with the Pathology Company or outside lab. Our office will be able to supply their phone number if needed. _____**Initial**

Printed Patient Name_____Date_____

Responsible Party Signature_____

Name_____

The Dermatology Center
Financial Policy

Payment: We accept cash, checks, money orders and credit cards (MasterCard, Visa, American Express and CareCredit). We request that you leave a credit card on file so that we may bill your final balance after all insurance monies have been paid. This will allow timely payment of your bill and will not in any way prevent you from inquiring about our insurance payments or your balance. We encourage you to call if you have any question about your bill or your insurance coverage.

I authorize any outstanding balance to be charged to my credit card listed below and to send me a copy of the transaction receipt:

<u>Circle One</u>: Visa MasterCard American Express

Card Number _____

Expiration Date_____

Name of Card Holder_____

Security Code _____ Your Zip Code_____

Responsible Party _____ Date ___/___ / ____

Name_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Dermatology Center may use and disclose protected health information (PHI) about me to carry out **treatment, payment and healthcare operations (TPO).** Please refer to The Dermatology Center's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. The Dermatology Center reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained by forwarding a written request to: Office Manager, The Dermatology Center, 3501 Lafayette Blvd., Fredericksburg, VA 22408.

I,_____, hereby authorize The Dermatology Center, and/or their representatives to release any and all information pertaining to my healthcare, results, procedures, and/or accounting information to the following person(s) or agencies:

- ☐ Myself only
- ☐ Spouse, full name:_____
- ☐ Parent, full name(s) _____
- ☐ Other(s) – Specify name and relationship _____

I further authorize The Dermatology Center and/or their representatives to release results of my medical exams in one or more of the following ways:

May call me (patient):

- ☐ At home between ___am/pm to ___am/pm
- ☐ At work between ___am/pm to ___am/pm

May leave a message:

- ☐ At home
- ☐ At work
- ☐ On answering machine at home and/or work

Email me: _____

I understand that this office will release any information to those persons who I have determined may receive this information without separate consent. I also understand that this relates to all medical and billing/account information. **THIS WILL BE ACTIVELY ENFORCED**. If you wish to change the status of this form, you must do so in writing.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, The Dermatology Center may decline to provide treatment to me.**

_____Date_____

Print Patient's Name

_____

Signature of Patient, Responsible Party, or Legal Guardian

Patient Declined to Sign_____ The Dermatology Center _____

Name_____

The Dermatology Center
Medical History Form

Past Medical History: Please check all that apply

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ **None**
- ☐ Other _____

Past Surgical History: *Please check 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
- ☐ PTCA
- ☐ 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
- ☐ 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
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ **None**
- ☐ Other _____

Skin Disease History: *Please check all that apply*

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ **None**
- ☐ Other _____

Name_____

Medical History Form (Continued)

Skin Disease History:

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)? ☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Maternal Grandparent(s) ☐ Paternal Grandparent(s)
☐ Other: _____

Flu Vaccination: (*Last date given*)
Date _____

Pneumonia Vaccination: (*Last date given*)
Date _____

Medications: (*Please list all current medications with strength and dosage)*

_____
_____
_____
_____

☐ Not currently taking any medications

Allergies: *(Please list all allergies)* ☐ No Known allergies

_____
_____
_____
_____

Social History: *(Please check all that apply)*

Cigarette Smoking:
☐ Never Smoked
☐ Quit: former smoker
☐ Smokes less than daily
☐ Smokes Daily
☐ Other _____

Alcohol Use:
☐ Yes
☐ No

Language:
☐ English
☐ Spanish
☐ Other _____

Race:
☐ White
☐ Black/African American
☐ Asian
☐ American Indian or Native Alaskan
☐ Native Hawaiian/Pacific Islander

Ethnicity:
☐ Hispanic/Latino
☐ non-Hispanic/Latino

Occupation and Workplace: _____

Place of Residence: _____

Name_____

Medical History Form (Continued)

Do you currently have any of the following conditions?

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (Hypertrophic or keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay fever
- ☐ Chest pain
- ☐ Fever or Chills
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression
- ☐ Allergy to Latex
- ☐ Allergy to adhesive
- ☐ Allergy to Lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within the past two years
- ☐ Blood Thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning a pregnancy
- ☐ **None**

What Pharmacy do you use?

Name:_____

Address:_____

_____

Phone:_____

Primary Care Physician:

Name:_____

Address:_____

_____

Phone:_____

Please sign below. By doing so, you certify that the responses provided in this questionnaire are complete and accurate to the best of your belief.

Patient Signature_____ **Date:**_____

(or responsible party, if minor)