

# 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?**  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 fee 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 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 ALL 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:**

**Circle One: 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.**

\_\_\_\_\_  
Patient’s Name Date \_\_\_\_\_ Print

\_\_\_\_\_  
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

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

**Past Surgical History:** Please check all that apply

- |  |   |
|--|---|
| <input type="checkbox"/> Appendix Removed                                | <input type="checkbox"/> Kidney Biopsy                              |
| <input type="checkbox"/> Bladder Removed                                 | <input type="checkbox"/> Kidney Removed (Right, Left)               |
| <input type="checkbox"/> Mastectomy (Right, Left, Bilateral)             | <input type="checkbox"/> Kidney Stone Removal                       |
| <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral)             | <input type="checkbox"/> Kidney transplant                          |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral)          | <input type="checkbox"/> Ovaries Removed: Endometriosis             |
| <input type="checkbox"/> Breast Reduction                                | <input type="checkbox"/> Ovaries Removed: Cyst                      |
| <input type="checkbox"/> Breast Implants                                 | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer            |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection               | <input type="checkbox"/> Prostate Removed: Prostate Cancer          |
| <input type="checkbox"/> Colectomy: Diverticulitis                       | <input type="checkbox"/> Prostate Biopsy                            |
| <input type="checkbox"/> Colectomy: IBD                                  | <input type="checkbox"/> TURP                                       |
| <input type="checkbox"/> Gallbladder Removed                             | <input type="checkbox"/> Skin Biopsy                                |
| <input type="checkbox"/> Coronary Artery Bypass                          | <input type="checkbox"/> Basal Cell Cancer Surgery                  |
| <input type="checkbox"/> PTCA  | <input type="checkbox"/> Squamous Cell Carcinoma Surgery            |
| <input type="checkbox"/> Mechanical Valve Replacement                    | <input type="checkbox"/> Melanoma Surgery                           |
| <input type="checkbox"/> Biological Valve Replacement                    | <input type="checkbox"/> Spleen Removed                             |
| <input type="checkbox"/> Heart Transplant                                | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="checkbox"/> Joint Replacement Knee (Right, Left, Bilateral) | <input type="checkbox"/> Hysterectomy: Fibroids                     |
| <input type="checkbox"/> Joint Replacement Hip (Right, Left, Bilateral)  | <input type="checkbox"/> Hysterectomy: Uterine Cancer               |
| <input type="checkbox"/> Joint Replacement within last 2 years           | <input type="checkbox"/> <b>None</b>                                |
| <input type="checkbox"/> Other _____                                     |   |

**Skin Disease History:** Please check all that apply

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Poison Ivy                |
| <input type="checkbox"/> Actinic Keratoses      | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Precancerous Moles        |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Blistering Sunburns    | <input type="checkbox"/> Hay Fever/Allergies    | <input type="checkbox"/> Squamous Cell Skin Cancer |
|   | <input type="checkbox"/> Melanoma               | <input type="checkbox"/> <b>None</b>               |
| <input type="checkbox"/> 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)

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Not currently taking any medications

**Allergies:** (Please list all allergies)

No Known allergies

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**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?**

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

**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)