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.

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 (NCNS): 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. This balance must be paid prior to making another appointment. _____Initial

Treatment of Minors: Any minor (under age 18) who is treated at The Dermatology Center **must have a parent/legal guardian present with them at all visits**. 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

Print Patient Name: _____ DOB ___/___ / ____

Patient Signature: _____ DATE ___/___ / ____

Parent and/or Guardian: **_____**

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 with minimal work on our part 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.

*Carecredit payments are only accepted onsite in person with matching ID.

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 CareCredit

Name of Card Holder_____

Card Number _____

Security Code _____ Card Zip Code _____ Expiration Date_____

Print Patient Name: _____ DOB ___/___ / ____

Patient Signature: _____ DATE ___/___ / ____

***Parent and/or Guardian:*_____**

_____ I do not wish to have my credit card on file

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: **Home Ph:** _____ **Mobile**: _____
- ☐ Spouse, full name:_____PH: _____
- ☐ Parent, full name(s) _____ PH: _____
- ☐ Other(s) – Specify name and relationship _____ PH: _____

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
- ☐ On mobile between _____am/pm to _____am/pm

May leave a message:

- ☐ At home
- ☐ On mobile
- ☐ 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.

_____ _____

Print Patient's Name **Date of Birth**

_____ _____

Signature of Patient, Responsible Party, or Legal Guardian **DATE**

Patient Declined to Sign_____ **The Dermatology Center Witness**_____

The Dermatology Center
Medical History Form

PATIENT NAME: _____ DOB:_____

Past Medical History: Please check all that apply

- Anxiety disorder
- Arthritis
- Asthma
- Atrial fibrillation
- BPH (Benign Prostatic Hyperplasia)
- Cerebrovascular accident
- COPD (Chronic Obstructive Lung Disease)
- Coronary Arteriosclerosis Disease (CAD)
- Depressive disorder
- Diabetes mellitus
- Disease caused by 2019 n-CoV
- Other

- Elevated Blood Pressure
- End stage renal disease
- Epilepsy
- Gastro Reflux Disease
- H/O hypertension
- Hearing loss
- Gastro Reflux Disease
- HIV/AIDS
- Hypercholesterolemia
- **HYPER**thyroidism
- **HYPO**thyroidism

- Inflammatory disease of liver
- Leukemia
- Malignant Lymphoma
- Malignant tumor of lung
- Malignant tumor of breast
- Malignant tumor of colon
- Malignant tumor of prostate
- Radiation therapy treatment
- Transplantation of bone marrow
- **None**

_____

Past Surgical History: *Please check all that apply*

- Abdominoperineal resection
- Bilateral replacement Knee
- Biopsy of breast
- Biopsy of prostate
- Coronary artery bypass graft
- Entire transplanted kidney
- Excision of basal cell carcinoma
- H/O: colostomy
- H/O: tubal ligation
- Appendectomy (Appendix removal)
- Gallbladder Removed
- Bilateral mastectomy
- Cholecystectomy (gallbladder removal)
- Colectomy (colon removal)
- Liver excision
- Percutaneous transluminal coronary angioplasty(PTCA)
- Tissue graft heart valve replacement
- Total Cystectomy
- Transurethral prostatectomy
- Other _____
_____

- Hysterectomy
- Kidney Biopsy
- Low anterior resection of rectum
- Lumpectomy (Right, Left, Bilateral)
- Mastectomy (Right, Left, Bilateral)
- Mechanical heart valve replacement
- Oophorectomy: Ovaries Removed: (one or both)
- Pancreatectomy: Pancreas Removed
- Extraction of Kidney Stones by procedure
- Portosystemic shunt (PSS)
- Prostatectomy: Prostate removal (partial or complete)
- Prosthetic arthroplasty of bilateral hips
- Splenectomy: spleen removal
- Surgical biopsy of the skin: Location:_____
- Total nephrectomy: removal of both kidneys
- Total orchidectomy: removal of both testicles
- Total replacement hip joint: (Right, Left or Both)
- Total replacement knee joint: (Right, Left or Both)
- Transplantation of heart
- Transplantation of liver
- **NONE**

Skin Disease History: *Please check all that apply*

- Acne
- Actinic Keratoses
- Dry Skin (asteatosis cutis)
- Basal Cell Skin Cancer
- Poison Ivy
- Other _____

- Dysplastic Nevus of skin
- Eczema
- H/O Asthma
- H/O Hay fever
- **Melanoma:** Location_____

- Itchy Scalp (Scalp Pruritus)
- Psoriasis
- Squamous cell carcinoma
- Sunburn
- **None**

Medical History Form (Continued)

PATIENT NAME: _____ DOB:_____

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: _____

Medications: (*Please list all current medications)*

• Not currently taking any medications

_____

_____

_____

_____

Allergies: *(Please list all allergies to medications or environmental)*

• No Known allergies

_____

_____

_____

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

<u>Cigarette Smoking:</u>

• Never Smoked

• Quit: former smoker

• Smokes less than daily

• Smokes Daily

• Other _____

<u>Alcohol Use:</u>

• Yes

***If Yes how many per day*:** • (0-1 drinks) • (1-2 drinks) • (2 or more)

• No

How often do you exercise?

• Once a day

• A few times a week

• A few times a month

• Never

What is your caffeine Use?

• Once a day

• A few times a week

• A few times a month

• Never

Medical History Form (Continued)

Do you currently have any of the following conditions?

- Allergy to adhesive
- Allergy to topical antibiotic ointments
- Artificial joints within the past two years
- Defibrillator
- Pacemaker
- Rapid heartbeat with epinephrine
- Problems with bleeding
- Problems with scarring (Hypertrophic or keloid)
- Immunosuppression
- Chest pain
- Night sweats
- Thyroid problems
- Blurry vision
- Bloody stool
- Joint aches
- Neck stiffness
- Seizures
- Shortness of breath
- Anxiety
- Allergy to Lidocaine
- Artificial heart valve
- Blood Thinners
- MRSA
- Premedication prior to procedures
- Pregnancy or planning a pregnancy
- Problems with healing
- Rash
- Hay fever
- Fever or Chills
- Unintentional weight loss
- Sore throat
- Abdominal pain
- Bloody urine
- Muscle weakness
- Headaches
- Cough
- Wheezing
- Depression

What Pharmacy do you use?

Name:_____

Street:_____

Zip:_____

Phone:_____

Occupation and Workplace: _____

Place of Residence: _____

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 Name: _____DOB:_____Date:_____

Parent and/or Guardian Name: _____ Relationship_____