DERM PATIENT REGISTRATION

THE SKIN WELLNESS CENTER

Date ________________ Who are you seeing today? ________________________

Patient's Full Name (legal) ____ Patient # ________________

Address ________________________________ City ________________ State ______ Zip __________

Home Phone ____________ Work ____________ Cell Phone ____________ Email ________________________

Preferred Primary Phone Number? Home ☐ Work ☐ Cell ☐ Where may we leave messages? Home ☐ Work ☐ Cell ☐

Birth Date ____________ Age ______ SS# ________________ Sex: M F Marital Status ____________ Full Time Student _____

Occupation ________________________ Employer/School ____________________________ Phone ____________

Spouse Name ________________________ Employer ________________________________ Phone ____________

Spouse Birthdate ____ SS# ____________________________

Race ________________ Preferred Language ________________ Ethnicity (Hispanic/Not Hispanic) ________________

Notify in Emergency ____________________________________ Phone ____________ Relationship ____________

Referring Doctor ________________________________ Primary Care Physician ________________________________

Financial Responsibility (if different than above)

All minors must be accompanied by a parent or legal guardian

Name ______________________________ Birthdate __________ Phone ____________ SS# ________________

Address ________________________________ City ________________ State ______ Zip __________

Employer ________________________________ Phone ____________ Relationship to Patient ____________

INSURANCE – PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance Carrier ____ Effective Date ________________

Subscriber's Name ____________________________ SS# ________________ Birthdate __________ Relation __________

Secondary Insurance Carrier ____ Effective Date ________________

Subscriber's Name ____________________________ SS# ________________ Birthdate __________ Relation __________

INITIAL

______ I consent to treatment necessary for the care of the above named patient.

______ I authorize the release of all medical records to the referring or treating physicians and to my insurance company, if applicable.

______ I allow fax transmittal of my medical records if necessary.

______ I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

______ If this account becomes past due, I agree to pay all reasonable collection costs. If legal action is required to collect this account, I agree to pay all attorney fee and court costs.

______ I further authorize and request that insurance payments be made directly to The Skin Wellness Center, should they elect to receive such payment.

______ I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

______ I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

Is there anyone you would like to give us permission to speak to? ________________________________ Relation ____________

Signature: ____ Date: ________________________

DERM MEDICAL HISTORY

THE SKIN WELLNESS CENTER

Patient Name: ______________________ Date: ____________ Patient Acct #: ____________

Reason for today's visit: ______________________ Referring Physician (if any): ____________

MY PHARMACY: Name: ____________ Location ____________ Phone ____________

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:

List all medications, vitamins, and herbals you are currently taking:

Do you have now, or have you ever had diseases or conditions of:

	Yes	No
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Pacemaker	☐	☐
Phlebitis	☐	☐
Depression/Anxiety	☐	☐
Mood or Behavioral Disorder	☐	☐

If yes, please specify: ____________

Other Systemic:

	Yes	No	If yes, please specify:
Diabetes: please specify type 1 or 2	☐	☐	________
Thyroid: please specify hypo or hyper	☐	☐	________
Kidney	☐	☐	________
Bladder	☐	☐	________
Bowel	☐	☐	________
Hepatitis	☐	☐	________
Glaucoma	☐	☐	________
Arthritis / Joint Deformity	☐	☐	________
Convulsions, Epilepsy or Seizures	☐	☐	
Fainting	☐	☐	
Herpes (fever blisters)	☐	☐	

Other medical conditions not listed: ____________

How often do you use a tanning bed? ☐ Never ☐ Occasionally ☐ Frequently ☐ Have used in the past

How often do you use sunscreen? ☐ Never ☐ Occasionally ☐ Frequently

Have you ever had skin cancer? ☐ Yes ☐ No If yes, what type? ____________ How long ago? ________

Has an immediate family member had melanoma? ☐ Yes ☐ No If yes, who? ____________

Do you have a history of any specific skin diseases? ☐ Yes ☐ No If yes, please list: ____________

Do you have a history of MRSA? ☐ Yes ☐ No

Please list the last date of the following:

- Last flu vaccine ________
- Last pneumonia vaccine ________
- Last colonoscopy ________
- Pap smear ________
- Mammogram ________

Have you had or have you been exposed to HIV (AIDS)? ☐ Yes ☐ No

Have you ever had local anesthesia? ☐ Yes ☐ No If yes, any bad reaction? ☐ Yes ☐ No

How tall are you? _____ ft. _____ in. How much do you weigh? ________ lbs.

Do you smoke? ☐ Yes ☐ No If yes, how much? ____________ If no, have you ever smoked? ☐ Yes ☐ No

Do you bleed easily? ☐ Yes ☐ No

Are you pregnant or breast feeding? ☐ Yes ☐ No If pregnant, what is your due date? ____________

Do you have artificial joint(s)? ☐ Yes ☐ No

What is your occupation? ____________

What are your hobbies? ____________

Our Dermatologists provide a wide range of skin rejuvenation products and services. Please let our staff know if you are interested in learning about these.

______________________ ____________

Signature of Patient or Patient's Representative **Date**

PRACTICE INFORMATION

THE SKIN WELLNESS CENTER

Patient Name ______________________________ Date ____________ Patient # ______________

Your Appointment

Your time is important to us. Your appointment time was scheduled based on the reason you gave us when you scheduled your appointment. If you have additional problems or need to discuss additional concerns with your provider, we will have to schedule another appointment to address these problems / concerns. This will allow us to be considerate of all our patients' time.

Late Arrivals

Out of respect for other patients arriving on time, if you arrive more than 15 minutes late, you may be asked to reschedule. However, arriving less than 15 minutes late DOES NOT guarantee that you will be seen. It is at the discretion of your health care provider whether you can be worked back in to the schedule.

Your Prescriptions

Unless you request a written prescription to take with you after your visit, prescriptions are sent electronically to your pharmacy. This often means that your prescription will not be ready for pickup until the end of the day. We strongly suggest you call your pharmacy to make sure your prescriptions are ready before going to pick them up.

Insurance companies often change their list of "preferred drugs". We try very hard to keep current with these changes. However, you may find that your insurance company has rejected your prescription because it is not on their "preferred list". Again, we suggest you call your pharmacy to make sure your prescription(s) are ready before going to pick them up. If your prescription is rejected by your insurance because it is not on their "preferred list", additional time will be required for approval of a substitute medication.

Cancellation/No-show Policy

We respectfully ask for 24 hours notice if you will be unable to keep an appointment. You may be charged a $25 fee for not showing for an appointment without giving us notice.

Co-pays and Fees for Service

All co-payments or payments for services rendered are expected at time of visit. If you are unable to pay your co-pay at time of visit, there will be an additional $8 fee added to your bill.

Consent to Treat Minors

Minors, persons under the age of 18, must be accompanied by a parent or legal guardian for all appointments. If it is necessary for a minor to come to appointments alone or with a friend or family member, we must have a statement in writing from a parent or legal guardian giving us permission to treat your child without the parents' presence. We have a form for minor consent that we can provide upon request.

Cell Phone Usage

Please be respectful of our employees, providers, and other patients by refraining from cell phone use while in our waiting and check in area and the exam rooms.

Lab

We participate only with Dermatopathology Partners, P.C. for all biopsy samples. Your insurance will be billed by Dermatopathology Partners and you are responsible to Dermatopathology Partners for any balance due after insurance.

For all other labs (blood work, urine samples) we use PathGroup which participates with most insurances. If your insurance plan requires you to use a different lab, please notify us at the time of your visit.

I acknowledge that I have read and understand the above statements and all questions have been answered to my satisfaction.

______________________________ ____________

Signature of Patient or Patient's Representative Date