NEW PATIENT REGISTRATION FORM

PATIENT'S PERSONAL INFORMATION

Sex ☐ M ☐ F

First Name ____ Middle ____ Last Name ____ Nickname ____

Social Security # ____ - ____ - ____ **Date of Birth** ____ / ____ / ____ (MM DD YY)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race ☐ White ☐ African American ☐ Asian ☐ Other ____ ☐ Decline

Ethnicity ☐ Non-Hispanic ☐ Hispanic ☐ Other ____ ☐ Decline

Preferred Language (if other than English) ____

Address Street ____ Apt ____ City ____ State ____ Zip ____

Phone Numbers

Home ____ **Cell** ____ **Work** ____

E-mail Address ____

Preferred Means of Communication ☐ Home ☐ Cell ☐ Work ☐ E-mail

PERSON RESPONSIBLE FOR BILL

Name ____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Date of Birth ____ / ____ / ____ (MM DD YY) **Phone** ( ) ____

Address Street ____ Apt ____ City ____ State ____ Zip ____

Guarantor E-mail Address ____

PRIMARY MEDICAL INSURANCE

Insurance Co. ____ **Employer** ____

Policyholder's Name ____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Social Security # ____ - ____ - ____ **Date of Birth** ____ / ____ / ____ (MM DD YY)

SECONDARY MEDICAL INSURANCE

Insurance Co. ____ **Employer** ____

Policyholder's Name ____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Social Security # ____ - ____ - ____ **Date of Birth** ____ / ____ / ____ (MM DD YY)

PRIMARY CARE PHYSICIAN

Full name ____ **Did this doctor refer you to us?** ☐ Yes ☐ No

PREFERRED PHARMACY

Name ____ **Address** (or intersection) ____

EMERGENCY CONTACT

Name ____

Relationship to Patient ☐ Spouse ☐ Parent ☐ Child ☐ Other

Phone ( ) ____

DERMATOLOGY ASSOCIATES FINANCIAL POLICY

This Document contains important information regarding our financial policies. Please carefully review the policies and sign in order to be seen by one of our providers.

Payment for Services
Payment is required for all services at the time the services are rendered. For in-network services this includes any co-pay, co-insurance and/or deductible. Insurance coverage is not a guarantee of payment by your insurance company. You are financially responsible for all services rendered on your behalf or on behalf of your dependents. If your insurance company fails to respond or does not pay promptly, we will forward the balance to you for payment.

Out-of-Network Services and Private Pay Patients
If we are not in network with your insurance, or if you are not insured, payment will be required at the time of service. It is your responsibility to verify with your insurance plan if we are a contracted provider.

Cosmetic Services
Services that are not medically necessary cannot be submitted to insurance. You will be asked to pay at time of service for any cosmetic procedures.

Dermatopathology
When a biopsy or surgical procedure is performed, the specimen(s) will be sent to a specialist physician (dermatopathologist) for microscopic examination. As a result, there will be two separate charges – one for the in-office procedure and another for the diagnosis of the specimen.

Laboratory Services
Some insurance companies require preferred laboratories for bloodwork. It is your responsibility to know the preferred laboratories under your insurance policy. Please let us know at each visit if a specific lab is required.

Delinquent Accounts and NSF Checks
We refer delinquent accounts to an outside collection agency. If your account is referred to a collection agency, a fee of up to 30% of your balance due, plus an administrative service fee of $25, will be assessed to your account. Your phone information will be used for collection efforts, including automated dialing systems (for which you may opt out at a later date).There is a $25 charge for checks returned for insufficient funds, and payment of the check and fee will be due immediately.

Financial Hardship
If you are facing financial hardship, please ask to speak to a patient account representative so that we may work with you. We want to help you understand the cost of your care. If you have any questions or concerns about this financial policy, please ask a staff member and we will be happy help.

Cancellation Policy
If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel at least 24 hours prior to the scheduled appointment. We reserve the right to charge the patient a $50 fee if that patients does not cancel the appointment 24 hours in advance. Additionally, we reserve the right to reschedule appointments to which the patient is more than 30 minutes late.

I have read this financial policy and I agree to meet my financial obligation related to the care that I, or my dependents, receive.

____	____________________
Print Patient Name	**Date of Birth**
____	____________________
Signature Patient or Legal Guardian/Responsible Party	**Date**

EVANS DERMATOLOGY

PERSONAL HEALTH HISTORY

All answers are confidential

PATIENT NAME ______________________________ DATE OF BIRTH ___ / ___ / ____

TODAY'S DATE ___ / ___ / ____ REASON FOR VISIT ______________________________

MEDICAL HISTORY

Allergies to medications ☐ **NONE**

Name of the drug	Reaction you had

List all medications, with strengths and dosages, including vitamins & supplements: ☐ **NONE**

When was your last Flu vaccine? **Month** _____ **Year** ______

When was your last Pneumonia vaccine? **Month** _____ **Year** ______

Have you ever had any of the following?

	Yes	No	If yes, please explain:
Allergies	☐	☐	☐ Seasonal ☐ Skin ☐ Other
Asthma	☐	☐	
Bleeding Problems	☐	☐	
Blood Transfusion	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	☐ Type I ☐ Type II
Eczema	☐	☐	
Heart Disease	☐	☐	
Hepatitis	☐	☐	☐ A ☐ B ☐ C ☐ Unknown
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
HIV	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Lung Disease	☐	☐	
Psoriasis	☐	☐	
Skin Cancer	☐	☐	☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Other ☐ Unknown
Thyroid Problems	☐	☐	

PATIENT NAME ______________________________ **DATE OF BIRTH** ___ /___ /___

Any other medical problems that other doctors have diagnosed?

____

____

Surgeries ☐ **NONE**

Year	Reason	Year	Reason
____	____________________	____	____________________
____	____________________	____	____________________
____	____________________	____	____________________

FAMILY HISTORY

Has anyone in your family ever had:

	Yes	No	Relationship	
Skin Cancer	☐	☐	____________	☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Other ☐ Unknown
Psoriasis	☐	☐	____________	
Other skin conditions	☐	☐	____________	Description ____________

HEALTH HABITS

What is your occupation? ______________________________

	Yes	No	Former User	
Do you use a tanning bed?	☐	☐	☐	If yes, how many times per week? ________
Do you smoke?	☐	☐	☐	If yes, how many packs per day? ________
Do you drink alcohol?	☐	☐	☐	If yes, how many drinks per week? ________
Do you use recreational drugs?	☐	☐	☐	If yes, what type? ____________

FEMALE PATIENTS ONLY

	Yes	No		Yes	No
Are you pregnant?	☐	☐	Using contraception?	☐	☐
			If yes, what type? ____________		
Breastfeeding?	☐	☐	Trying to get pregnant?	☐	☐

COSMETIC CONCERNS (optional)

Some of our patients would like more information about the cosmetic treatment of sun damage and aging skin. Do you have any cosmetic concerns you would like to discuss? ☐ Yes ☐ No

MESSAGES REGARDING LAB/PATHOLOGY RESULTS

When we are unable to reach you directly regarding benign/normal lab or pathology results, we typically leave a voicemail or answering machine message with the result(s). The decision about whether to leave a detailed message is at the discretion of the staff of Evans Dermatology.

☐ I DO NOT want to receive any results on my voicemail or home answering machine. Please ONLY leave callback details.

EVANS
DERMATOLOGY
PARTNERS

ACKNOWLEDGEMENT OF OFFICE POLICIES

Insurance Filing Authorization

I certify that the information contained in my registration and health history forms is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Evans Dermatology Partners. I also authorize Evans Dermatology Partners or insurance company to release any information required to process my claims. I agree that a photocopy or scan of this agreement shall be as valid as the original.

Notice of Privacy Practices

I have read a copy of Evans Dermatology Partner's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I authorize the release of any medical information necessary to process insurance claims on my behalf. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

Payment Policies

Payment is due at time of service. This amount includes any co-pay as well as the amount of outstanding insurance deductible or co-insurance. I understand that I am financially responsible for all charges for services rendered on my behalf or on behalf of my dependant, whether or not they are covered by my insurance.

Cancellation Policy

If the patient cannot adhere to scheduled appointment, it is the patient's responsibility to call the office to cancel at least 24 hours prior to the scheduled appointment. Evans Dermatology Partners reserves the right to charge the patient a $50 fee if the patient does not cancel the appointment at least 24 hours in advance. Additionally, Evans Dermatology Partners reserves the right to reschedule appointments to which the patient is more than 30 minutes late.

Formulary Benefits and Prescription History

Formulary Benefits data are maintained by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. By signing below I give permission for Evans Dermatology Partners to attempt to obtain prescription benefits data electronically and, if possible, to download a historic list of all medications prescribed for me by any medical provider.

Authorization to Disclose Medical Information (OPTIONAL)

I hereby authorize the physicians and the staff of Evans Dermatology Partners to disclose any and all details of my medical diagnosis, treatment and billing/claims information to the following individuals. **You do not need to list your other physicians.**

Name	Relationship	Phone
___________________	__________________	( ) _____ - _______
___________________	__________________	( ) _____ - _______

❒ **I elect <u>not</u> to authorize disclosure to any individuals at this time**

This authorization is voluntary and I understand that I have the right to revoke this authorization by submitting a written request to the office manager for Evans Dermatology Partners. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the above list may not be exhaustive and that my protected health information may be disclosed to additional individuals based on my verbal authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

Patient Name ___________________________ **Date of Birth** ____________________ **Parent/Guardian Name** *(if applicable)* ________________________

Signature ________________________________ **Date** ____________