NEW PATIENT REGISTRATION FORMS

APPOINTMENT DATE & TIME: _____

Name: _____

Optional - Preferred Name: _____ *Pronouns:* _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____
Address: _____
STREET CITY STATE ZIP
Phone: _____
HOME CELL WORK

Email: _____@_____
Would you like to receive email/text message reminders? YES ☐ NO ☐

Primary Care Physician: _____Phone: _____
Referring Physician (If not same as above) _____

PRIMARY Insurance Information:

_____
Name/Type Policy Holder's Name/DOB Relationship to Patient
_____
Insurance Number Policy Holder's Address (if different from above)

SECONDARY Insurance Information (if applicable):

_____
Name/Type Policy Holder's Name/DOB Relationship to Patient
_____
Insurance Number Policy Holder's Address (if different from above)

Parent/Guardian Authorization for Patients Under the Age of 18

I, the undersigned, certify that I am the parent or legal guardian of the minor named above. I affirm that I have legal authority to complete these forms and to make medical decisions on behalf of this child.

I give my consent to South County Dermatology, LLC and its medical providers to evaluate, diagnose, and treat the above-named minor. This includes any routine medical care, diagnostic procedures, and treatments deemed necessary by the provider.

Printed Name of Parent/Guardian: _____Relationship: _____

Signature of Parent/Guardian: _____Date_____

MEDICAL HISTORY FORM

NAME: _____ DATE OF VISIT: _____

Past/Present Medical History: (please circle all that apply)

Anemia
Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH-Enlarged Prostate
Breast Cancer
Cerebral Vascular Accident -CVA
Colon Cancer
COPD – Pulmonary Disease
Coronary Artery Disease
Dementia
Depression
Diabetes
Elevated Blood Pressure
End Stage Renal Disease
GERD - Acid Reflux
Hearing Loss
Hepatitis - A/B/C
High Cholesterol
HIV/AIDS
Leukemia
Lung Cancer
Lymphoma
Pacemaker/Defibrillator
Prostate Cancer
Radiation Treatment
Seizures
Stroke (CVA)
Thyroid Disease:
Hyperthyroid
Hypothyroid
Valve Replacement

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Surgery
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: Inflammatory Bowel Dis.
Gallbladder Removed
Coronary Artery Bypass
Heart Valve Replacement
Heart Transplant
Hysterectomy
Joint Replacement, KNEE (Right, Left, Bilateral) Year_____
Joint Replacement, HIP (Right, Left, Bilateral) Year_____
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Liver Transplant
Lung Transplant
Ovaries Removed
Prostate Removed: Prostate Cancer
Prostate Biopsy
Prostate – TURP
Skin Biopsy_(Year)_____
Spleen Removed
Testicles Removed (Right, Left, Bilateral)

Other _____

Current Skin Problems: What is the primary reason for your visit?

☐ Full Skin Exam ☐ Rash ☐ Changing Mole ☐ Acne ☐ Psoriasis ☐ Warts ☐Cosmetic Consult

☐Other_____

Skin Disease History: (please circle all that apply)		
Acne	Eczema	Precancerous Moles
Actinic Keratoses	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Rosacea
Blistering Sunburns	Melanoma	Squamous Cell Skin Cancer
Dry Skin	Poison Ivy	Warts

Other _____

Do you wear Sunscreen? ☐ NO ☐ YES If YES, what SPF? _____

Do you tan in a tanning salon? ☐ NO ☐ YES

Do you have a family history of Melanoma? NO ☐ YES ☐ = (Relative_____)

Pharmacy_____

Address _____ **Phone**_____

Medications: (Please list all current medications or attach a sheet listing medications)

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: (Please list all Allergies to Medications, Food, Environmental)

_____ _____

_____ _____

Emergency Contact:

Name:_____Relationship: _____Phone: _____

Do you authorize us to share your health information with your emergency contact person? YES ☐ NO ☐

Social History:

☐ Never Smoked ☐ Former Smoker ☐ Daily Smoker ☐ Occasional Smoker

Responses to the next two questions are at the request of the Federal Government.

1. **Race** ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Other _____
2. **Ethnic Group** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

We would like to know a little more about you:

Occupation: _____Employer: _____

How did you hear about us? _____

Other family members who are patients: _____

Hobbies/Interests: _____

 Review of Systems:

Please check YES or NO to each of the following as they apply to you for TODAY'S VISIT

SYMPTOM	YES	NO
Problems with Bleeding		
Problems with Healing		
Problems with Scarring (Hypertrophic/Keloid)		
Immunosuppression		
Changing Mole		
Rash		
Abdominal pain		
Anxiety		
Bloody Stool or Bloody Urine		
Blurry Vision		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Pacemaker or Defibrillator		
Artificial Heart Valve		
Artificial Joints – (Hip, Knee) within the past 2 years		
Antibiotics needed prior to dental procedures? (Prophylaxis)		
Allergy to Adhesive (Tape, Band-Aids)		
Allergy to Antibiotic Ointments (Neosporin, Bacitracin)		
Blood Thinners (Aspirin, Coumadin/Warfarin, Plavix, Eliquis, Xarelto)		
Pregnant, Planning Pregnancy, Nursing Mother		
Allergy to Lidocaine		
Rapid Heartbeat with Epinephrine		
Yeast Infection with Antibiotics		
GI upset with Antibiotics (Nausea, Diarrhea)		

South County Dermatology

Patient Financial Policies and Responsibility Form

Please read and sign this Form to acknowledge that you understand its content and accept financial responsibility for the services provided by our office. We aim to clearly communicate our policies to our patients: if you have any questions, please speak with our Practice Manager, Nancy Stonely.

General Policy

Payment for service is due in full at the time service is provided. We accept checks, cash, and most major credit cards. Patients can arrange a payment plan including pre-authorized charges to a credit card. Patients may incur additional charges at the discretion of the practice, including but not limited to a charge for returned checks; a charged for missed appointment without a 24-hour-notice: a charge for the completion of time-consuming forms; and costs associated with the collection of past-due balances.

Policy for Patients with Private Insurance Plans and/or Medicare

We accept most major insurance plans and will submit bills to primary insurance carriers. We also will bill most secondary insurance companies for patients. Patients are expected to provide us with the most updated insurance information.

Co-payments are due at the time of service. Patients are responsible for knowing the amount of their deductible. If a deductible has not been met, charges against the deductible are due on the date of service. Sometimes the exact amount of the portion of the charges owed by patients will not be known until after we submit an insurance claim. If, however, you have a plan with a large deductible that you have not met at the time of your visit, you are expected to make a substantial and reasonable payment at that time.

If a referral and/or prior authorization for either a visit or procedure is necessary under a particular insurance plan, patients are responsible for obtaining the referral or authorization before the office visit.

Policy for Patients Receiving Cosmetic Services

Generally, cosmetic services are not covered by insurance; therefore, payment is expected at the time of service. In rare instances, we may attempt to collect payment from an insurance company for a procedure that we believe is medically necessary, but the company may determine that it is cosmetic in nature. In those situations, patients are financially responsible, and we will bill the patient for the full amount owed.

Agreement to Accept Financial Responsibility

I have read and I understand the above information, and I agree to accept responsibility.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

South County Dermatology
Patient Privacy Practices Acknowledgment and Consent Form

Notice of Privacy Practices

We are committed to maintaining the privacy of your protected healthcare information. Pursuant to the Federal Health Insurance Portability and Accountability Act (HIPAA), South County Dermatology's Privacy Notice outlines how HIPAA permits us to use and disclose your protected health information (PHI); it also describes your right under HIPAA, and it states that we have an obligation to protect the privacy of your health information.
Importantly, our Privacy Notice describes how we use and disclose PHI:

- to provide you with medical treatment nd ensure the quality of your care:
- to bill and collect payment for services; and,
- to support the operations of our Practice.

We encourage new patients to review our Privacy Notice, which is available upon request from our helpful staff upon check-in and via our website.

Acknowledgment and Consent

By signing below, I acknowledge that I have reviewed the Privacy Notice or that I have been provided with the opportunity to review it. I understand that the Notice may change and that I will have an opportunity to inquire about and review any revised Notice by contacting South County Dermatology.

I give my consent for South County Dermatology to use and disclose PHI about me to provide me with medical treatment, to process payment, and to support the Practice's operations. I may revoke consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

Patient Name (print): _____ Date: _____

Patient Signature (if age 18 or older): _____

Parent/Guardian (if patient is under 18) Signature: _____

Patient's Representative (if applicable) Name (print): _____

Signature: _____ Relationship to Patient: _____