NORTHSHORE DERMATOLOGY
THE COMPLETE SKINCARE AND LASER CENTER
Eric N. Tabor, M.D.

Patient Registration Form

Name: _____ □ Jr. □ Sr. Date: _____
Last First Middle

Prefer to be called: _____ □ Married □ Single

Date of Birth ____/_____/_____ Patient's Social Security Number _____-____-_____

Gender: _____ Gender Pronoun: _____

Mailing Address: _____ City _____ State _____ Zip_____

Home phone: _____ Work phone: _____ Cell phone: _____

How did you hear about us? _____ Email: _____

Preferred Contact Method:
The preferred method of contact will assist us in providing you important information such as: upcoming specials and promotions, birthday specials, events, and pathology results.

I prefer to be contacted via: □Text: □Cell Phone: □Home Phone: □Work Phone: □Email

Employer Name: _____ Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder (Guarantor) if other than patient: _____ Relationship: _____
Guarantor's D.O.B.: _____/_____/_____
Prescription Drug Plan: _____

Legal Guardian or Custodial Parent of Minor: _____ Relationship: _____

Do we have your permission to:
Leave a voicemail-at home or cell phone? □ Yes □ No
Leave a voicemail with normal lab results? □ Yes □ No
Discuss your medical condition with another member of your household? □ Yes □ No
If yes, whom: _____ Relationship: _____

Medical History

Patient Name _____

Reason for today's visit: _____

Would you like a full body exam today? □ Yes □ No Primary Care Physician: _____

Do you have any allergies (medications, food, etc)? □ Yes □ No
If yes, please list: _____

List all medications you are currently taking, including NSAIDS/Aspirin/Anticoagulants daily:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Preferred Pharmacy: _____ Location: _____

FEMALE ONLY:
Are you pregnant? □ Yes □ No If pregnant, Due Date: _____
Are you planning to become pregnant? □ Yes □ No
Are you currently breastfeeding? □ Yes □ No
History of Breast Cancer □ Yes □ No If yes, when and how was it treated? _____
If you are between the ages of 51-74 have you had a mammogram in the past two years? □ Yes □ No

If you are between the ages of 50-75 have you had a colonoscopy in the last nine years? □ Yes □ No
Have you experienced a fall or problem with gait or balance? □ Y □ N

***Height_____ ***Weight_____**

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

Asthma	□ Y	□ N	Stomach	□ Y	□ N	Thyroid	□ Y	□ N
High Blood Pressure	□ Y	□ N	Hepatitis	□ Y	□ N	High Cholesterol	□ Y	□ N
Heart Attack	□ Y	□ N	Glaucoma	□ Y	□ N	Bleeding	□ Y	□ N
Irregular Heartbeat	□ Y	□ N	Arthritis	□ Y	□ N	Kidney	□ Y	□ N
Pacemaker	□ Y	□ N	Seizures	□ Y	□ N	HIV (AIDS)	□ Y	□ N
Diabetes	□ Y	□ N	Artificial Joints	□ Y	□ N			

Family History:

If any immediate blood relative has any condition listed below, check and specify which relative.

No Relevant Family History	□_____	High Blood Pressure	□_____
Unknown – Adopted	□_____	High Cholesterol	□_____
Diabetes	□_____	Thyroid Disease	□_____
Heart Disease	□_____		

Skin:

When you are exposed to sun do you:	□ Tan only	□ Tan and burn	□ Burn
Have you ever had skin cancer?	□ Yes	□ No	
Has anyone in your family had skin cancer?	□ Yes	□ No	If yes, who? _____
Do you have a history of any skin diseases?	□ Yes	□ No	

If yes, please list: _____

Social History:

Do you smoke?	□ Yes □ No	If yes, how much? _____	How often? _____
Do you drink alcohol?	□ Yes □ No	If yes, how much? _____	How often? _____
Do you use recreational drugs?	□ Yes □ No	If yes, what? _____	How often? _____

List any other disease or condition we should know about: _____

List any surgical procedures you have had in the last 6 months: _____

What is your occupation? _____

What are your hobbies? _____

Please list your daily skin care regimen here: _____

_____

_____

No Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy.
Please **Give 24 hours** notice to cancel appointment.
When you need to cancel or rebook a scheduled visit, please contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient.
If you miss 2 or more appointments, fees may apply before you are allowed to schedule another appointment.

Sure Script:

Patient consents to view sure scripts all-doctor drug history.

MIPS Reporting

Northshore Dermatology is a participant in the "MIPS" program which is the use of certified Electronic Health Record (EHR) technology to achieve health and efficiency goals. In order to be compliant with the standards, we are required to collect specific data from our patients. Please answer the few questions below.

Race:

□ Caucasian □ Asian □ African American □ Pacific Islander □ Hispanic or Latino □ American Indian
□ Other _____

Ethnicity:

□ Not Hispanic or Latino □ Hispanic or Latino □ Other _____

Preferred Language:

□ English □ Spanish □ Other _____

ACKNOWLEDGMENT OF PRIVACY POLICY

I, _____, (Print Name) have been given a copy of the Notice of Privacy Practice of Eric N. Tabor, M.D. APMC.
Your signature on this form confirms your understanding of these policies and your agreement to comply with the above stated terms.

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. Applicable copayments and deductibles will be collected. **PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES,** unless you are in a prepaid plan in which we participate. We accept payment in the form of cash, check, Visa, MasterCard, and Discover. Your signature below indicates that you understand and accept the above policy. Furthermore, your signature authorizes the doctor to release such medical information necessary to process you insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

(Initial) ____ I understand CareCredit financing is an option for me to use as payment for Cosmetic and other healthcare expenses at Northshore Dermatology.

_____ _____
Signature of Patient or Legal Guardian Date