



PATIENT REGISTRATION
(PLEASE PRINT)

PATIENT INFORMATION

Last Name: First Name: MI: Birth Sex: M F
Address:
City: State: Zip: Date of Birth: Age:
Home Phone: Cell Phone: Preferred Phone#: home/cell
OK to leave message? Yes No Email:
Race/Ethnicity: American Indian Asian Black Hispanic/Latino White Other:
Occupation: Employer:
Emergency Contact: Relationship: Phone:
Primary Care: Preferred Pharmacy:

For Minor Patients Only: * All minor (17yo and under) visits require a legal guardian.

Parent/Guardian #1: Relationship: Phone:
Date of Birth: Employer:
Parent/Guardian #2: Relationship: Phone:
Date of Birth: Employer:

Disclosure of Protected Health Information (PHI) and Billing or Payment Information (optional):

YES, I authorize disclosure of my PHI and/or billing and payment information to the following individual(s):
NO, I DO NOT authorize to disclosure of my PHI and/or billing and payment information.

Name: Relationship: Phone: PHI Billing
Name: Relationship: Phone: PHI Billing

INSURANCE INFORMATION

Primary Insurance Policy:

Primary Policy Holder: Relationship to Patient: Date of Birth:
Insurance Company: Policy #: Group #:

Secondary Insurance Policy:

Primary Policy Holder: Relationship to Patient: Date of Birth:
Insurance Company: Policy #: Group #:

Patient Signature (legal guardian): Date:

Patient Name: _____

Date: _____

PATIENT HISTORY
(PLEASE PRINT)

Please complete the following sections, to the best of your knowledge, concerning your current or past medical history.

CURRENT OR PAST MEDICAL CONDITIONS

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> End stage renal disease | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Cancer (type): _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Coronary Arteriosclerosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depressive disorder | <input type="checkbox"/> High cholesterol | |
| <input type="checkbox"/> Other Medical Conditions: _____ | | |

PRIOR SURGERIES

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Joint Replacement: _____ | <input type="checkbox"/> Testicles |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Kidney | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Colon | <input type="checkbox"/> Ovaries | |
| <input type="checkbox"/> Other Surgeries: _____ | | |

SKIN CONDITIONS

- | | | |
|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Rash | <input type="checkbox"/> Skin Cancer: Basal Cell |
| <input type="checkbox"/> Actinic Keratosis (pre-cancer) | <input type="checkbox"/> Itch 1-10 _____ | <input type="checkbox"/> Skin Cancer: Melanoma |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Skin Cancer: Squamous Cell |
| <input type="checkbox"/> Eczema | | |
| <input type="checkbox"/> Other: _____ | | |

PLEASE CHECK ALL THAT APPLY

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergy to adhesive | <input type="checkbox"/> Headaches | <input type="checkbox"/> Premedication prior to procedures |
| <input type="checkbox"/> Allergy to lidocaine | <input type="checkbox"/> Immunosuppressants | <input type="checkbox"/> Problems with bleeding |
| <input type="checkbox"/> Allergy to topical antibiotics | <input type="checkbox"/> Joint aches | <input type="checkbox"/> Problems with healing |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> MRSA | <input type="checkbox"/> Problems with scarring/keloids |
| <input type="checkbox"/> Artificial joints within past two years | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Rapid heartbeat with epinephrine |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Unintentional weight loss |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Fever or Chills | <input type="checkbox"/> Pregnant or planning pregnancy | |
| <input type="checkbox"/> Other: _____ | | |

Patient Name: _____

Date: _____

PATIENT HISTORY cont.
(PLEASE PRINT)

PATIENT WEIGHT: _____

PATIENT HEIGHT: _____

MEDICATION:

Continue on back page if needed

___ **NO Current Medications**

___ **NO Changes**

Prescription Medications:

Over-The-Counter Medications:

Do we have permission to reconcile your medications with your pharmacy?

Yes ___ No ___

Allergies:

___ **NO known drug allergies**

ADDITIONAL QUESTIONS

Do you have a family history of Melanoma? Yes No

Do you use tobacco products? No Past Current (please circle type): Cigarettes Tobacco Vape

Do you drink alcohol? No Yes (how many per week?): _____

Do you have an advance directive or living will? No Yes, Name: _____

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes No

ONLY PATIENTS 17 AND YOUNGER:

Have you received the meningococcal vaccine? Yes No

Have you received the Tdap or Td vaccine? Yes No

Have you received the HPV vaccine? Yes No

ONLY PATIENTS 65 AND OLDER

Have you received a pneumonia vaccination? No Yes



Financial & Office Policies

We would like to thank you for choosing Pine Belt Dermatology & Skin Cancer Center for all your dermatological needs. Pine Belt Dermatology & Skin Center is committed to providing you with the best possible medical care. The following outlines your financial responsibilities related to payment for professional services.

No Show Fee:

Please Kindly give 48-hour notice if you are unable to keep your follow up appointment. Our office reserves the right to charge your account **\$25.00** in the event you do not show for your scheduled appointment.

No Show Surgical Appointment Fee:

Please Kindly give a 48-hour notice if you are unable to keep a surgical appointment. Please note there will be a fee of **\$200.00** added to your account in the event you do not show for your surgical appointment.

No Show Cosmetic Fee:

Please kindly give 48-hour notice if you are unable to keep your cosmetic appointment. Please note there will be a fee of **\$65.00** added to your account in the event you do not show for your cosmetic appointment.

For Our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many HMO's, PPO's Insurance companies and government agencies including Medicare and Medicaid. Our business office will assist you in any way reasonable we can to get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid.

Co- Payments:

Your insurance company required us to collect co- payments at the time of service. Waiver of co-payments constitutes fraud under state and federal law. For your convenience, we accept cash, checks, or the following credit cards: Visa, MasterCard, Discover, American Express and Care Credit.

Additionally, you may have coinsurance and/or deductibles, or other financial responsibility required by your insurance carrier. Any outstanding balance on your account, after adjusting for all your insurance responsibilities, will be billed to you.

Patient Signature (legal guardian): _____ **Date:** _____



Financial & Office Policies cont.

Non-Covered and Out of Network Services:

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Payment Plan:

Please let us know if you are having difficulty paying your account. We are more than willing to make arrangements that will fit your budget.

Delinquent Balance Appointment:

If you have a balance of more than 120 days old, you will be required to pay an additional amount towards the outstanding balance, and a payment plan must be set up.

Collection Agency Fees:

All patients' balances that require placement with an outside collection agency will be assessed a fee of 35% for the total balance owed on the account.

Cosmetic Services:

Services for cosmetic procedures or any service deemed non-medically necessary by the provider, are required to be paid in full at the time of service.

Waiver of Patient Responsibility:

It is the policy of the Practice to treat all patients in an equitable fashion related to patient balances. The practice will not waive, fail to collect or discount co-payments, co-insurance, deductibles, or other patient responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Charity/Free Care Policy.

Photography:

Our Providers require the use of photography in your medical chart. In short, it is another way to identify the patient and the medical record. Our office does not sell or distribute your personal information including pictures to any outside source. The only exception to this is for payment of your medical claim, your consent and request or required by law enforcement.

Patient Signature (legal guardian): _____ **Date:** _____