PBD
Pine Belt Dermatology

102 E Hospital Dr
Hattiesburg, MS 39402
Phone: (601) 475-9968
Fax: (601) 4759969

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

Social Security Number: ____-____-____ Email: _____

Race/Ethnicity: American Indian Asian Black Hispanic/Latino White Other: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care: _____ Preferred Pharmacy: _____

____ I hereby consent to receive text messages and voicemails at the number provided, including appointment reminders. Standard message and data rates may apply.

___ I DO NOT consent to receive text messages and voicemails at the number provided, including appointment reminders. Standard message and data rates may apply.

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: _____

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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

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

PRIOR SURGERIES

- ☐ Appendix
- ☐ Bladder
- ☐ Brain
- ☐ Breast
- ☐ Colon
- ☐ Gallbladder
- ☐ Heart
- ☐ Joint Replacement: _____
- ☐ Kidney
- ☐ Ovaries
- ☐ Pancreas
- ☐ Prostate
- ☐ Testicles
- ☐ Uterus
- ☐ Other Surgeries: _____

SKIN CONDITIONS

- ☐ Acne
- ☐ Actinic Keratosis (pre-cancer)
- ☐ Dry Skin
- ☐ Eczema
- ☐ Rash
- ☐ Itch 1-10 ____
- ☐ Psoriasis
- ☐ Skin Cancer: Basal Cell
- ☐ Skin Cancer: Melanoma
- ☐ Skin Cancer: Squamous Cell
- ☐ Other: _____

PLEASE CHECK ALL THAT APPLY

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

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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 advanced 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 65 AND OLDER

Have you received a pneumonia vaccination? ☐ No ☐ Yes

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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. 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:** _____

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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:** _____