Medical & Surgical Dermatology Center of NE Texas, PA
Patient Registration Form

Patient Name: _____ **Previous Name**: _____

Mailing Address: _____

Physical Address: _____

Home Phone (_____) _____ **Cell Phone** (_____) _____ **Work Phone:** (_____) _____ ext:___

Contact preference: □**Home** □**Work** □ **Cell** □ **Email**

Social Security Number: _____ **Date of Birth**: _____

Male o **Female** o **Married** o **Single** o **Divorced** o **Widowed** o **Separated** o

Race o American Indian oAsian oNative Hawaiian/Pacific oBlack/African American oWhite oHispanic oOther

Student Status : o Full Time o Part time o N/A **Primary Language:** o English o Spanish o Indian o Other

Employer_____

Spouse Name_____ **DOB**_____

Primary Care Physician _____ o I authorize Medical & Surgical Dermatology Center of NE Texas, PA to disclose my medical information pertaining to my **diagnosis and/or treatment, laboratory results, medical history .**

Referring Physician _____

Complete If Patient is Under 18

Mother's Name: _____ DOB: _____ SSN: _____

Address_____

Father's Name: _____ DOB: _____ SSN: _____

Address_____

Complete if Insurance is Carried by someone other than patient

Insurance Name: _____ Social Security #_____

Policy Holder Name: _____ DOB _____ Relationship to Patient: _____

Phone INFORMATION and COMMUNICATION RELEASE

Emergency Contact:

_____
Name Telephone # Relationship

May we leave personal medical information on your : o **Home phone** o**Work phone** o**Cell phone**

I authorize Medical & Surgical Dermatology Center of NE Texas, PA to disclose my medical information pertaining to my **diagnosis and/or treatment, laboratory results, medical history**, or any other such related information to these listed below and (**physician, family member, etc**)

_____
Name Telephone # Relationship

_____
Name Telephone # Relationship

_____
Name Telephone # Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

_____
Signature of patient/Legally authorized representative Date Relationship

Medical & Surgical Dermatology Center of NE Texas, PA

PATIENT PORTAL:
The patient portal is a secure web portal that allows you as a patient to access medical records including Medications, lab results and medical history via the internet. It also allows you to communicate with our office via secure messaging. We offer the portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses without your written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.
The portal should only be used for non-urgent concerns and should not be used for emergency communication. Providing your Email below consents use of the patient portal

EMAIL: _____ ○ Decline/ Do not have Email

Patient Authorization for ePRESCRIBE
ePrecribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of **Medical & Surgical Dermatology Center of NE Texas, PA** to enroll me in the ePrescribe Program. .

Initial_____

Patient Authorization for PHARMACY BENEFITS MANAGER
I authorize the physician and/or staff of **Medical & Surgical Dermatology Center of NE Texas, PA** to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payors for treatment purposes.

Initial_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES
The " **Notice of Privacy Practices"** of Medical & Surgical Dermatology Center of NE Texas, PA, are available at our front desk and online to view at www.dermatologycenteroftx.com. This Notice explains how medical information is used and disclosed. I understand I am entitled to a copy of this document if I so desire.

Initial _____

Signature _____Printed Name _____

Date signed _____

Medical & Surgical Dermatology Center of NE Texas, PA

PATIENT FINANCIAL POLICY

Thank you for choosing our office for your care. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions regarding this policy, please discuss them with our practice manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of this policy as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have out-of-network benefits our charges for your care and treatment are due at the time of service. In the event your health plan determines a service is "not covered," "not medically necessary" or a "cosmetic procedure" you will be responsible for the complete charges.
- For services rendered to minor patients, the accompanying parent or guardian is responsible for payment.
- Although benefits may be verified at time of service, please note this is not a guarantee of payment.
- Patient balances are due within 30 days of receipt of statements. At that point, additional charges may be applied. We will work with you to make payment arrangements. If these efforts do not result in resolution of the account, the account may be referred to a collection agency; you will be responsible for any and all fees charged by the collection agency. These fees will be added to your account.
- If your insurance plan denies payment for any reason, you will be responsible for payment. It is your responsibility as the patient to pay the denied amounts in full. If patient does not agree with denied claims it is patient responsibility to contact insurance company.
- If you need laboratory services (pathology, wound culture), you will receive a separate bill from the pathology laboratory for said tests.
- Our appointments book out 1-3 weeks in advance, and we block a significant amount of time for your appointment. ***If you do not appear for your appointment or cancel with less than 24 hours notice, you will be charged a no-show fee of $25 for missed office visit***. This fee is not covered by your insurance company.

PAYMENT POLICY: *It is my responsibility to confirm that the physician is a covered provider under my insurance plan.* I hereby authorize the assignment of benefits (payments) directly to Medical & Surgical Dermatology Center of NE Texas, PA for all my insurance claims related to services received. I understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles/ coinsurance with any managed care contract and non-covered services. I have read, understood, and agree to the financial and cancellation policies above.

Signed (insured person)_____ Date_____

AUTHORIZATION TO PAY BENEFITS PHYSICIAN: I hereby authorize Medical & Surgical Dermatology Center of NE Texas, PA to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit to insurance companies.

Signed (insured person)_____ Date_____

MEDICARE/ MEDICARE ADVANTAGE PATIENTS ONLY:

MEDICARE RELEASE: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. Photocopy shall be valid as original.

Signed (insured person)_____ Date_____

MEDIGAP RELEASE: For Medicare patients with supplemental Medigap insurance, a separate signature is needed. I request Medigap benefits be made on my behalf for services rendered. I authorize to be released to my Medigap carrier any information needed to determine benefits.

Signed (insured person)_____ Date_____

Medical History

Date: _____

Patient: _____ Pharmacy: _____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list:

1. _____ 2. _____

List all Medications you are currently taking:

1. _____ 3. _____

2. _____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑

Vascular:

High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heart Beat	❑	❑
Pacemaker	❑	❑
Phlebitis	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder	❑	❑
Stomach	❑	❑
Bowel	❑	❑
Hepatitis or Yellow Skin	❑	❑
Glaucoma	❑	❑
Arthritis/Joint Deformity	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day

Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How much? _____

Have you had or have you been exposed to HIV (AIDS)? ❑ YES ❑ NO

Have you ever had dental anesthesia (Novacaine)? ❑ YES ❑ NO Any bad reactions? ❑ YES ❑ NO

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 specific skin diseases? ❑ YES ❑ NO

If yes, please list: _____

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

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

Please answer the following questions:

A. Do you smoke? ❑ YES ❑ NO If YES, how much: _____

B. Do you bleed easily? ❑ YES ❑ NO

C. (Women) Are you pregnant? ❑ YES ❑ NO Due Date: _____

D. Do you have artificial joint(s)? ❑ YES ❑ NO

E. What is your occupation? _____

F. What are your hobbies? _____

Completed by: ❑ Patient

❑ Medical Assistant _____
Initials

_____
Signed by Physician Date

_____
Reviewed by Date