my dermatologist
TRUSTED SKIN CARE

Patient Registration

Last Name:	First Name:	MI:	Previous name (if applicable)
Mailing Address:	*City/State/Zip:*		
Home Phone:	Cell Phone:	Work Phone:	
Social Security #:	Date of Birth:	Sex: Male ☐ Female ☐	
Receive Phone Apt Reminders ☐Yes ☐No	Where may we leave a detailed voicemail (choose one) ☐Home ☐Cell ☐Work ☐None		
In above detailed voicemail, can test results be communicated? ☐ Yes ☐ No			
Email Address:	What may we use email communication for? ☐ Set up your patient portal ☐ Appointment Reminders ☐ News & Events ☐ Financial Communication		
Who referred you to our clinic?	Your Primary Doctor's name:		
Pharmacy Name & Location:			
Race*:* ☐ Hispanic ☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Other ☐ Decline	**Ethnicity***: (select one only please)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline		
Preferred Language: ☐ Sign Language ☐ Indian (including Hindi & Tamil) ☐ English ☐ Spanish ☐ Russian ☐ Bosnian ☐ Other	**Emergency Contact** : Phone: Relationship:		
Responsible Party (Where bill will be sent): Name:			
Date of Birth:	Social Security #:	Phone:	
Address of Person Responsible:		City/State/Zip:	
Relationship to Patient:			

Primary Medical Insurance	***Secondary Medical Insurance***
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Address if not same:	Policy Holder's Address if not same:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Please initial each line item and sign below (the last two statements are for Medicare patients only)

_____ I have read and agree to My Dermatologist financial and clinical policy

_____ I was offered a copy of My Dermatologist Notice of Privacy Practices.

_____ RECORDS RELEASE: I authorize My Dermatologist to release medical records and billing information to my primary care and referring physicians.

_____ ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to My Dermatologist for services rendered to myself and/or dependents in addition to authorizing My Dermatologist or insurance company to release any information required to process my claims.

_____ MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to My Dermatologists on my behalf. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine these benefits or the benefits payable for related services. If you have a supplemental policy and it is a MEDIGAP policy which your insurance automatically crosses over, we are required to keep a separate signature on file.

_____ MEDIGAP: I request authorized MEDIGAP benefits be made on my behalf for services rendered to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits payable for related services.

Signature of Patient / Legal Guardian:_____ Date _____

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Acknowledgement of Receipt
Notice of Privacy Practices

A **NOTICE OF PRIVACY PRACTICES** is provided to all patients on their first visit. This Notice of Privacy Practices identifies how medical information about you may be used or disclosed. It explains your rights to access your medical information; to request an accounting of disclosures of your medical information and to request addition restrictions on our uses and disclosures of that information. It explains your rights to complain if you believe your privacy rights have been violated, and our responsibilities for maintain the privacy of your medical information, and letting you know if that privacy is breached.

The undersigned has received a copy of the **NOTICE OF PRIVACY PRACTICES** and is the patient or the patient's personal representative.

Name of Patient and Personal Representative (if applicable)

Patient Date of Birth

Signature

Date

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Medical History

Name_____ Date of Birth_____

What is the reason for your visit?_____

_____

_____

Medications: (Please enter all current medications)

_____

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

☐Adhesive, ☐Latex, ☐Lidocaine, ☐Epinephrine, ☐Bacitracin, ☐Neosporin/neomycin,

Past Medical History:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplant
- ☐ Bleeding disorder
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Heartburn/reflux
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ HSV/Cold sores
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other Cancers -

_____

_____

_____

Other _____

Past Surgical History: (Please enter all surgeries)

_____

_____

- ☐ Blood thinners - aspirin, ibuprofen, NSAIDS, coumadin, vitamin E, Plavix,
- ☐ Fainting or syncope
- ☐ MRSA
- ☐ Hepatitis
- ☐ HIV
- ☐ Abnormal scarring
- ☐ Pacemaker/Defibrillator
- ☐ Prolapsed mitral valve
- ☐ Organ transplant
- ☐ Immunosuppressed
- ☐ Leukemia - CLL
- ☐ Artificial heart valve
- ☐ Artificial joint replacement
- ☐ Require antibiotics prior to a surgical procedure.

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Medical History

Skin Disease History:

☐ Acne	☐ Dry Skin	☐ Melanoma
☐ Actinic Keratoses	☐ Eczema	☐ Precancerous Moles
☐ Basal Cell Cancer	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Blistering Sunburns	☐ Hay Fever/Allergies	☐ Squamous Cell Cancer

Other _____

Do you wear Sunscreen? ☐Yes ☐No If yes, what SPF? _____

Do you tan in a tanning salon? ☐Yes ☐No

Family History:

☐ Acne	☐ Hay Fever/Allergies	☐ Psoriasis
☐ Basal Cell Cancer	☐ Melanoma	☐ Squamous Cell Cancer
☐ Eczema	☐ Precancerous Moles	

Other _____

Social History:

Occupation_____ **Hobbies**_____

Cigarette Smoking:

☐Currently smokes
☐Has smoked in the past
☐Never smoked
☐Former smoker

Alcohol Use:

☐None
☐Less than 1 drink per day
☐1-2 drinks per day
☐3 or more drinks per day

Do you have any of the following symptoms?

☐No ☐Yes	Fever or chills	☐No ☐Yes	Diarrhea/constipation
☐No ☐Yes	Night sweats	☐No ☐Yes	Joint pain
☐No ☐Yes	Fatigue	☐No ☐Yes	Rash or itchy skin
☐No ☐Yes	Unexplained weight loss	☐No ☐Yes	Hives
☐No ☐Yes	Swollen lymph nodes	☐No ☐Yes	Leg swelling
☐No ☐Yes	Blurry vision/Eye irritation	☐No ☐Yes	Blood clots
☐No ☐Yes	Chronic cough	☐No ☐Yes	Easy bruising
☐No ☐Yes	Shortness of breath	☐No ☐Yes	Immunosuppression
☐No ☐Yes	Chest pain	☐No ☐Yes	Headaches/Dizzy
☐No ☐Yes	Abdominal pain	☐No ☐Yes	Depression
☐No ☐Yes	Nausea/Vomiting	☐No ☐Yes	Trouble sleeping

WOMEN:

☐No ☐Yes	Pregnant	☐Yeast infections
☐No ☐Yes	Trying to get pregnant	☐Hysterectomy
☐No ☐Yes	Nursing	☐Tubal
☐No ☐Yes	Birth control_____	☐Endometrial ablation

_____ _____

Signature of patient/guardian **Date**