Petrin Dermatology

Patient Registration Form **Today's Date**:_____

Patient Information

Name: _____ **Date of Birth**: _____/_____/_____
Last First MI

Marital Status: □Married □Divorced □Single □Other: _____ **Social Security #**:_____ **Sex**: □Female □Male

Ethnic Group: □Hispanic or Latino □Not Hispanic or Latino □Decline to Specify **Preferred Language:** _____

Race: □Decline to Specify □White □American Indian or Alaska Native □Asian □Black or African American □Other: _____

Preferred Contact Method: □Phone □Email □Letter □Decline to Receive Reminders

Emergency Contact: _____ **Emergency Contact Phone Number**:_____-_____-_____
Last First

Referring Doctor and/or Primary Care Doctor: _____

Patient Contact Information

Mobile Phone:_____-_____-_____ **Home Phone:**_____-_____-_____**Preferred Phone:** □Mobile □Home

May we leave a ***detailed*** message on voicemail, text, answering machine, or with another person regarding an appointment, lab/biopsy results, or other medical concerns? □**YES** □**NO**

Email:_____**Opt in to email notifications?:** □Yes □No

Street Address:_____

City:_____ **State**: _____ **Zip code**: _____

Insurance Information

Primary Insurance

Insurance Name_____

Subscriber Name_____

Subscriber's Birthdate:____/_____/_____ **Sex:** □**M** □ **F**

Secondary Insurance

Insurance Name_____

Subscriber Name_____

Subscriber's Birthdate:____/___/ _____ **Sex:** □**M** □ **F**

Release Of Information

I give permission to the following person(s) to speak with anyone from Petrin Dermatology about my health condition, billing information, and any other relevant information. Expires 3 years from date of signature.

Name:_____ Phone: _____-_____-_____ Relation to Patient:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and I understand that I am financially responsible for any balance. I also authorize Petrin Dermatology or insurance company to release any information required to process my claims.

PATIENT / GUARANTOR SIGNATURE:_____ **DATE**:_____

Petrin Dermatology

Clinic Policies

I, the undersigned, hereby authorize Petrin Dermatology to receive the benefits to which I, or my dependents are entitled to under by health insurance plan. **I understand that all fees are my responsibility, and I will pay Petrin Dermatology the full amount after my insurance company has processed claims**. All accounts 90 days past due will be referred for collections. The undersigned shall pay all reasonable collection expenses including interest on the unpaid balance at 1% per month from the date of service, and/or reasonable attorney fees and court costs.

COPAYMENTS: All patients that have a co-payment agreement with their insurance company are required to pay their co-payment amount at the time of each appointment.

WE CANNOT TREAT A MINOR* (child under the age of 18) without written consent of their parent or guardian. If the patient is a minor, please ask the reception staff for the additional paperwork that can be kept on file for treatment when not brought in by their parent. This allows others such a grandparents, older siblings, as you specify to bring the minor in for treatment.

APPOINTMENT CANCELLATION: We require 24-hour notice for appointment cancellations. If you do not cancel your appointment within that timeframe, you will be charged $40.00.

LATE ARRIVALS: In consideration of other scheduled patients, should you arrive more than 15 minutes late for your scheduled appointment time, you may be required to reschedule your appointment

$100.00 FEE FOR MISSED SURGICAL APPOINTMENTS: Your insurance company will not cover this fee.

INSUFFICENT BILLING INFORMATION: We will bill your insurance for you, provided you supply us with accurate billing information. Ultimately, you are responsible for all charges incurred with us. If you should arrive for your first scheduled appointment with lack of billing information, you may be required to reschedule the appointment for a time with you are able to provide the required billing information.

$40.00 FEE FOR 'INSUFFICIENT CHECKING FUNDS': This fee will be assessed to your account for each check returned for 'insufficient funds'. You will be responsible for payment of this fee, as well as the amount of the original 'insufficient funds' check before your next scheduled appointment.

For those patients without insurance, we offer a 10% discount when paying for their services on the same day of the visit. This discount is only applied specifically to the physician portion of the care and is not applicable to the lab or supplies associated with the visit. This discount is not available if paid after the date of service.

I, the undersigned, authorize the release of all pertinent information contained within my medical records which may be necessary to process this claim for insurance benefits.

Signature by the patient/guarantor authorize Petrin Dermatology to render service and guarantees payment by the responsible party.

PATIENT / GUARANTOR SIGNATURE:_____ **DATE**:_____

PATIENT / GUARANTOR PRINTED NAME:_____

Petrin Dermatology

Medical History

Name: _____ **Date of Birth:**_____

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____
_____
_____

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Postate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____
_____
_____

Petrin Dermatology

Have you had any of the following?

- [ ] Acne
- [ ] Actinic Keratoses
- [ ] Asthma
- [ ] Basal Cell Skin Cancer
- [ ] Blistering Sunburns
- [ ] Dry Skin
- [ ] Eczema
- [ ] Flaking or Itchy Scalp
- [ ] Have Fever / Allergies
- [ ] Melanoma
- [ ] Poison Ivy
- [ ] Precancerous Moles
- [ ] Psoriasis
- [ ] Squamous Cell Skin Cancer
- [ ] NONE
- [ ] Other

Do you wear Sunscreen?

◯ Yes ◯ No

If yes, what SPF? _____

Do you tan in a tanning salon?

◯ Yes ◯ No

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

_____

Medications

List all current medications:

_____

_____

_____

_____

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

_____

Smoking Status (please choose one):

- [ ] Current everyday smoker
- [ ] Current someday smoker
- [ ] Former smoker
- [ ] Never smoker
- [ ] Unknown if ever smoked

Alcohol Intake (please choose one):

- [ ] None
- [ ] 1 or less per day
- [ ] 1-2 per day
- [ ] 3 or more per day

Social History (please choose one):

- [ ] Not Sexually Active
- [ ] Sexually active with one partner
- [ ] Sexually active with more than one partner
- [ ] Same sex partner

Are You Currently Experiencing any of the following? Please Circle All That Apply.

Problems With Bleeding
Problems With Healing
Problems With Scarring
Immunosuppression
Changing Mole
Rash
Abdominal Pain
Anxiety
Bloody Stool
Bloody Urine
Blurry Vision
Chest Pain
Cough
Depression
Fever Or Chills
Headaches
Hay Fever
Joint Aches
Muscle Weakness
Neck Stiffness
Night Sweats
Seizures
Shortness Of Breath
Sore Throat
Thyroid Problems
Unintentional Weight Loss
Wheezing
Pacemaker
Defibrillator
Artificial Joints Within The Last 2 Years
Artificial Heart Valve
Premedication Prior To Procedures
Allergy To Adhesives
Allergy To Topical Antibiotics
Blood Thinners
Pregnancy Or Planning A Pregnancy
Allergy To Lidocaine
Rapid Heartbeat With Epinephrine
Gi Upset With Antibiotics

Preferred Pharmacy:

_____

Location:

_____