Dermatology Professionals, PA

Patient Registration Form

Preferred site for future appointments: Baxter Bemidji

Outreach Location: Aitkin Crosby Little Falls Long Prairie Wadena

Patient's Full Name _____ Gender: __Male __Female

Marital Status: __S __M __W __D Date of Birth _____ Social Security #:_____

Mailing Address _____

City _____ State _____ Zip Code _____

Preferred Phone #: _____ __Home __Cell Alt Phone #:_____ __Home __Cell

Place of Employment: _____ Work Phone #:_____

Email Address: _____

Preferred Language: ___ English ____ Other: _____

Race: __White __Native American __Black __Hispanic __Asian __Hawaiian/Pacific Islander __Other

PERSONAL RELEASE:

Please indicate if you authorize Dermatology Professionals to leave or discuss information with any other person:

___ No ___ Yes for the following: ___ Medical ___ Financial ___ Appointment Information (future dates/times)

Name: _____ Relationship: _____

___ Same phone # as patient __ Different Phone #: _____

EMERGENCY CONTACT:

___ Same Contact Information as in Personal Release Section

___ No Name: _____ Relationship: _____

___ Same phone # as patient __ Different Phone #: _____

(This information is necessary for our files and will be considered confidential)

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____ Copay $_____ (due date of service)

Group # _____ ID # _____

POLICY HOLDER (If Other Than Patient):

Full Name_____ Relationship: _____

__ Male __ Female Date of Birth: _____ Social Security #:_____

___ Same address as patient __ Different Address: _____

City _____ State _____ Zip Code _____

Phone #: _____ __Home __Cell

Place of Employment: _____ Work Phone #:_____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____ Copay $_____ (due on day of service)

Group # _____ ID # _____

POLICY HOLDER (If Other Than Patient):

Full Name_____ Relationship: _____

__ Male __ Female Date of Birth: _____ Social Security #:_____

___ Same address as patient __ Different Address: _____

City _____ State _____ Zip Code _____

Phone #: _____ __Home __Cell

Place of Employment: _____ Work Phone #:_____

Dermatology Professionals, PA

AUTHORIZATION FOR RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

RECORD RELEASE: I authorize Dermatology Professionals, PA to release medical information about me to my insurance carriers, the Social Security Administration or its intermediaries/carriers, Centers for Medicare & Medicaid Services (CMS) and its agents for purposes of payment, and to referring physicians and other
providers involved in my care.

_____**Initial**

PHOTOGRAPHS: I hereby give permission to my provider or any assistant designated, to take photographs to enhance the medical record and for diagnostic purposes. I understand that they may show them to other health professionals to assist with my medical care and for educational purposes within the clinic.

_____**Initial**

ASSIGNMENT OF BENEFITS: I authorize payment of Medical/Medicare benefits to Dermatology Professionals, PA for any services furnished by this clinic to me. I understand that I am financially responsible for charges not covered by Medicare and/or my insurance carriers. This authorization also covers charges generated by Dermatology Professionals, PA and their physicians for services received at St. Joseph's Medical Center or other medical facilities.

_____**Initial**

PRIVACY PRACTICE: I hereby acknowledge that I have been offered a copy of the Dermatology Professionals, PA Notice of Privacy Practices.

_____**Initial**

FINANCIAL POLICY: I hereby acknowledge that I have been offered a copy of the Dermatology Professionals, PA Financial Policy.

_____**Initial**

I permit a copy of this authorization to be used in place of the original.

SIGNATURE_____DATE_____

(Relationship if patient is a minor:_____)

Dermatology Professionals History and Intake Form (R7) **Time:_____**

Account #_____

PBL NTM BRW KMB JAT

Patient Name: _____ Date of Birth_____

Height _____ Weight_____

Primary Physician _____

Preferred Pharmacy _____City_____

Past Medical History: (please circle all that apply)

Anxiety	Arthritis	Artificial Joints
Asthma	Atrial Fibrillation	BPH
Bone Marrow Transplant	Breast Cancer	Colon Cancer
COPD	Coronary Artery Disease	Depression
Diabetes	Renal Disease	GERD
Hearing Loss	Hepatitis	Hypertension
HIV/AIDS	Hypercholesterolemia	Hypothyroidism
Hyperthyroidism	Leukemia	Lung Cancer
Lymphoma	Pacemaker	Prostate Cancer
Radiation Treatment	Seizures	Stroke
Valve Replacement	**Other: _____**	

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP
Coronary Artery Bypass	Skin Biopsy
PTCA	Basal Cell Cancer Surgery
Mechanical Valve Replacement	Squamous Cell Carcinoma Surgery
Biological Valve Replacement	Melanoma Surgery
Heart Transplant	Spleen Removed
Joint Replacement, Knee (Right, Left, Bilateral)	Testicles Removed (Right, Left, Bilateral)
	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
	None

Other _____

Skin Disease History: **(please circle all that apply**)

Acne	Actinic Keratosis	Asthma
Basal Cell Skin Cancer	Blistering Sunburns	Dry Skin
Eczema	Flaking or Itchy Scalp	Hay Fever/Allergies
Melanoma	Poison Ivy	Precancerous Moles
Psoriasis	Squamous Cell Skin Cancer	None

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(s)? _____
Any other family history: _____

Medications: **(Please enter all current medications)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medication Allergies: (include reaction)

_____
_____

Social History: (**Please circle all that apply**)
Alcohol Use: None/< 1 drink per day/1-2 drinks a day/3 or more drinks per day
Cigarette Smoking: Never/former smoker/Smokes less than daily/smokes daily
Illicit Drug Use: Drug Use/IV Drug Use

Alerts: Are you currently experiencing any of the following? **Please Check yes or no**

Alert	Yes	No
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints with past 2 years		
Blood thinners		
Defibrillator		
History of MRSA		
Pacemaker		
Premedication prior to procedures		
Rapid heartbeat with epinephrine		
Pregnancy, planning a pregnancy or breast feeding		