

# PATIENT REGISTRATION FORM

Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Daytime / Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_ *Would you like to receive monthly emails about cosmetic specials from our office?* Y / N

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Sex: M / F Marital Status S / M / D / W

Primary Care Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Please list any family members who also see Dr. Brown \_\_\_\_\_

**Do we have permission to:** Leave a message on your cell phone? \_\_\_\_\_ voicemail at home? \_\_\_\_\_ at work? \_\_\_\_\_

Discuss your medical condition with any member of your household? \_\_\_\_\_ If yes, whom: \_\_\_\_\_

**Please enter information on the person responsible for the bill if other than the patient.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

**Spouse Information (if applicable)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_ Work / Daytime phone \_\_\_\_\_

**Emergency Contact (Nearest relative or friend)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**Insurance Information**

Insurance Carrier \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_

Your Relationship to Policy Holder \_\_\_\_\_

Patient (or Guardian Signature) \_\_\_\_\_ Date \_\_\_\_\_

## **Guarantor Agreement / Acknowledgement of Notice of Privacy Practices**

I authorize Tricia Brown MD to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Tricia Brown MD. I understand that Tricia Brown MD will file my insurance claim as a courtesy to me, and as such, is not required to wait for extended delays in payment. I understand that I am fully responsible for any non-covered services, denied services, health insurance deductibles, or unassigned portion of charges at this office.

I have received a copy of the Notice of Privacy Practices for Tricia Brown MD. I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice. I know that if I do not consent, services cannot be provided to me.

### ***I have read and understand all of the following:***

- 1) Payment (in the form of cash, check or credit card [Visa, Mastercard]) is due for all services and/or copayments at the time of visit. We unfortunately do not accept American Express.
- 2) Returned checks will be charged a \$30 fee to cover processing and bank fees.
- 3) Overdue accounts are subject to a \$75.00 late fee after 60 days. In the event that a delinquent account must be turned over to collections, the patient is responsible for all attorney fees, court costs and collection agency fees associated with the collection process.
- 4) In order to provide the best possible service and availability to all our patients, it is office policy to charge a \$75 fee for any regular appointments not cancelled with the front desk by phone at least two business days prior. This fee is NOT covered by insurance and is the full responsibility of the patient. Please call us as early as possible if you know you will need to reschedule your appointment. Cancellations should be made with our front desk staff by phone, rather than by email, text, or voicemail. For surgery appointments, medical procedures, and cosmetic procedures, a \$200 no-show fee will apply. All appointments require a \$50 deposit (or \$200 deposit for longer visits) in order to reserve the appointment. This will be happily refunded if the appointment is cancelled at least 2 business days prior.
- 5) **HMO (Managed care) patients:** It is the responsibility of HMO patients to ensure that they have obtained a referral for all appointments with this office, if needed. The patient is financially responsible for any and all services rendered that are not a part of the referral, if not covered or paid by insurance. If you did not get a referral for a specialist office visit, your insurance company will require you to pay the full amount for all services.
- 6) **PPO patients:** Most insurance companies consider all dermatology procedures (such as skin biopsies or freezing off warts) to be surgical in nature. They will often apply these costs to your deductible. When we verify insurance for your appointment, we are given a general idea about your coverage, but we will not know exactly what they cover until we send off the claim and receive an explanation of benefits (EOB). It is a good idea for you to become well acquainted with the specifics of your coverage. If you want to delay a particular procedure until you know these details, the front desk staff will be happy to provide you with the appropriate medical codes for you to give to your insurance company.
- 7) **Labwork and pathology services of biopsies** are sent to an outside lab for processing. The lab will bill the insurance and/or patient separately for this service. We do not know the specific prices, as this is negotiated between the insurance and the lab. Please notify us beforehand if you would like the phone number of the lab to call them for a price quote prior to the procedure.
- 8) **Insurance coverage:** It is the patient's ultimate responsibility to ensure that we are covered on their particular health plan. While our office always checks beforehand for insurance coverage and verification, we have found that insurance companies do not always give us accurate information and they do not guarantee coverage or payment. We do our best to determine these issues beforehand, but we also rely on the patient to directly call their insurance plan and be fully aware of their coverage. **NOTE:** We will gladly file your insurance claim on your behalf. We allow 3 months for the insurance company to pay and will try to appeal any payment denials. If the insurance company does not pay after 3 months, the patient will be fully responsible for the entire balance.
- 9) **We are no longer contracted with Medicare or Blue-Cross Blue-Shield,** but we do have discounted self-pay rates and can see patients of any age, with or without insurance.
- 10) In order to provide the best care for patients, complete skin/mole checks are performed on an office visit separate from medical evaluations for other issues (i.e. skin rash, acne, hair loss, etc.). We are still able to refill straightforward medications during a mole check, and we will be happy to check one or two concerning lesions during a medical evaluation for other conditions.
- 11) **Parents of young children:** While we strive to provide a safe environment for everyone, medical exam rooms can be a dangerous place for unsupervised children. Please watch your children closely, or you may prefer to keep young children at home. For their safety, it is extremely important to keep them away from the medical waste trash can, the drawers and cabinets, and the Doctor's rolling stool. At your request, we can remove some of these items from the room for you.

Patient (or Guardian) Signature \_\_\_\_\_

Date \_\_\_\_\_

# Dermatology Medical History

Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Do you have any specific skin diseases? \_\_\_\_\_

Please list all medications (including over-the-counter & herbals): \_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications?  Yes  No Please list \_\_\_\_\_  
\_\_\_\_\_

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Do you have now, or have you ever had any of the following diseases or conditions?

|  | Yes                      | No                       | Other Systemic                          | Yes                      | No                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| <b>History of Cancer (other than skin)</b> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Location _____                             |                          |                          | Thyroid problems                        | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Lungs / Allergies</b>                   |                          |                          | Yeast infections on antibiotics         | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma / Wheezing                          | <input type="checkbox"/> | <input type="checkbox"/> | Fainting                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath                        | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions or seizures                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Bee or wasp sting allergy*</u>          | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/joint deformity               | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Cardiovascular</b>                      |                          |                          | Artificial joint                        | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure                        | <input type="checkbox"/> | <input type="checkbox"/> | Depression                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack / heart disease               | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular heartbeat                        | <input type="checkbox"/> | <input type="checkbox"/> | Autism spectrum disorder                | <input type="checkbox"/> | <input type="checkbox"/> |
| Inflammation of veins                      | <input type="checkbox"/> | <input type="checkbox"/> | <b>Gastrointestinal</b>                 |                          |                          |
| Blood clots                                | <input type="checkbox"/> | <input type="checkbox"/> | Gastric bypass, sleeve, or lap band     | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker                                  | <input type="checkbox"/> | <input type="checkbox"/> | Nausea, vomiting, diarrhea              |                          |                          |
|  |                          |                          | when taking antibiotics                 | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | Celiac disease, Crohn's or Ulc. colitis | <input type="checkbox"/> | <input type="checkbox"/> |

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last year: \_\_\_\_\_

**Skin:**

|   | Yes                      | No                       |                                  |
|---|--------------------------|--------------------------|----------------------------------|
| Have you ever had skin cancer?                    | <input type="checkbox"/> | <input type="checkbox"/> | Body area & date of cancer _____ |
| Has anyone in your family had melanoma?           | <input type="checkbox"/> | <input type="checkbox"/> | Which family member? _____       |
| Do you have problems with healing?                | <input type="checkbox"/> | <input type="checkbox"/> |                                  |
| Do you develop keloids (bad scars) after surgery? | <input type="checkbox"/> | <input type="checkbox"/> |                                  |
| Do you bleed easily?                              | <input type="checkbox"/> | <input type="checkbox"/> |                                  |

Do you develop skin rashes in reaction to:  Medications  Food  Environment? \_\_\_\_\_

**Social History:**

|   | Yes                      | No                       |   |
|---|--------------------------|--------------------------|---|
| Do you drink alcohol?                               | <input type="checkbox"/> | <input type="checkbox"/> | If yes, _____ drinks per week; or, _____ drinks per month |
| Do you smoke?                                       | <input type="checkbox"/> | <input type="checkbox"/> | If yes, how many packs per day : _____                    |
| Does anyone around you smoke?                       | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Do you wear sunscreen regularly?                    | <input type="checkbox"/> | <input type="checkbox"/> |   |
| Do you have or have you been exposed to HIV (AIDS)? | <input type="checkbox"/> | <input type="checkbox"/> |   |

**Women:**

|                               |                          |                          |  |
|-------------------------------|--------------------------|--------------------------|--|
| Are you pregnant?             | <input type="checkbox"/> | <input type="checkbox"/> | Due Date _____   |
| Are you breastfeeding?        | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Are menstrual cycles regular? | <input type="checkbox"/> | <input type="checkbox"/> | Date of last cycle _____ <input type="checkbox"/> Menopause <input type="checkbox"/> Other _____ |

Signature \_\_\_\_\_