ANTHONY DEE, MD PLLC
DERMATOLOGIC CENTER FOR EXCELLENCE

PATIENT REGISTRATION FORM Date_____

Patient Name:_____ DOB:_____ Sex: ☐ M ☐ F
Address:_____
City/State/Zip:_____
Email:_____ Social Security #:_____
Please provide contact information and *indicate your preferred contact number*:
☐Home Phone:_____ ☐Cell: _____
May we leave a message? ☐ Y ☐ N May we text you to confirm appointments? ☐ Y ☐ N
Employer:_____ Occupation: _____Phone:_____
Pharmacy Name:_____ Phone:_____
Primary Care Physician: _____
Referred By:_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Ethnic Group
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline

Race
- ☐ White
- ☐ African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other Race

Emergency Contact:_____Relationship:_____Phone:_____
Minor patient's parent/guardian name:_____Phone:_____
Who is *financially* responsible for patient? _____
Address, if different from patient:_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____
Policy Holder:_____ Relationship to patient:_____
Policy Holder DOB:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____
Policy Holder:_____ Relationship to patient:_____
Policy Holder DOB:_____

I hereby authorize Dr. Anthony Dee to furnish information to insurance carriers concerning my illness and treatments, and I do hereby assign to the physician all payment for medical service rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature:_____ **Date**:_____

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PATIENT INTAKE FORM

Patient Name_____ Date of Birth_____ Date_____

Chief complaint today: _____

_____

Select any of the following medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension/High Blood Pressure
- ☐ Hypercholesterolemia/High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None
- ☐ Other_____

Please list any past surgical procedures and dates: _____

_____

_____

Do any of the above procedures require that you take an antibiotic before the dentist (premedicate)? Yes No

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma** When? _____
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other_____ _____
- ☐ None

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

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

Do you have an *immediate* family history of melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Do you drink alcohol? (**REQUIRED**)

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

Do you smoke? (**REQUIRED**)

- ☐ Never smoked
- ☐ Former smoker
- ☐ Current every day smoker
- ☐ Current some day smoker

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Patient Name_____ Date of Birth_____ Date_____

Please list any medications you are currently taking, including over-the-counter:

Medication	Dose	Frequency	Date Started

Are you allergic to any medications? ☐ Y ☐ N If yes, please list: _____

_____

For new patients only: Are you experiencing difficulty ***today*** with any of the following:

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic/keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Anxiety
- ☐ Depression
- ☐ Muscle Weakness
- ☐ Unintentional Weight Loss
- ☐ Thyroid Problems
- ☐ Sore Throat
- ☐ Blurry Vision
- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Chest Pain
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Joint Aches
- ☐ Muscle Aches

Alerts: Do you have any of the following?

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning a pregnancy

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Do we have your permission to:

Leave a message on your answering machine at home/cell? _____ yes _____ no
Leave a message at your place of employment? _____ yes _____ no
Obtain prescription history? _____ yes _____ no
Discuss your medical condition with any member of your household? _____ yes _____ no
If yes, whom: _____ Relationship _____

This consent was signed by: _____
(Printed Name-Patient or Representative) (Relationship)

_____
(Signature) (date)

Witness: _____
(Signature) (date)

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FINANCIAL POLICY

Our staff is committed to providing you with the best medical care possible. Our office participates in a variety of insurance plans. If you have an insurance plan in which we do not participate, you will be **required** to sign an out-of-network waiver and our office will be happy to assist you in filing the insurance claim upon request. However, payment in full is expected at the time of service and your insurance company will reimburse you accordingly.

If you have questions regarding your insurance, we will try to help. However, questions relating to specific coverage issues must be directed to your insurance company's member services department. Their telephone number is usually on the back of your card.

The following apply to every visit.

- Bring your insurance card.
- **Be prepared to pay your co-payment amount.** We accept cash, check and credit card payments. The fee for returned checks is $25.
- For medical care not covered by your insurance, payment in full is due at the time of the visit.

Co-payments and deductibles: **Please be prepared to pay your co-payment amount at each visit.** We will not waive or discount co-payments or deductible payments that are **required** by your health insurance carrier.

Referrals: Many insurance plans require a referral from your primary care physician to be seen by a specialist. To avoid delays, please bring any required referral for treatment at the time of your visit. If you do not have a required referral, your visit may be rescheduled or you may be financially responsible.

Delinquent accounts: Please remember that it is your responsibility to pay your bill in full when you are billed. We realize that there may be extraordinary circumstances which make it impossible to do so. If you are experiencing such difficulties, we may be able to make special arrangements in your case, but only if you call the office for assistance. **A charge of the current billing rate will be assessed for missed or cancelled appointments without 24 hour advance notice. Missed or cancelled surgical appointments less than 24 hours in advance will be assessed a $100.00 fee.**

***Effective April 15, 2019*: All delinquent accounts over 30 days will be subject to a monthly fee of $10.**

I certify that I have read and understand this financial policy.

Signature _____ Date _____