

**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

Race

Hispanic or Latino

White

Not Hispanic or Latino

African American

Decline

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Atrial Fibrillation
(irregular heartbeat) | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Bone Marrow
Transplantation | <input type="checkbox"/> GERD | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hypertension/High Blood
Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypercholesterolemia/High
Cholesterol | <input type="checkbox"/> Stroke |
| | | <input type="checkbox"/> 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?

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Melanoma** | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blistering Sunburns | When? _____ | _____ |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> 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:

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

Alerts: Do you have any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Allergy to adhesive | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Allergy to lidocaine | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Allergy to topical antibiotic ointments | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Premedication prior to procedures |
| <input type="checkbox"/> Artificial joints within past two years | <input type="checkbox"/> Rapid heartbeat with epinephrine |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> 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. An account referred to an outside collection agency will be charged an additional 25% collection fee on the unpaid balance. You will also be responsible for additional service fees, interest and attorney's fees while your account is in collection.

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

Signature _____ Date _____