PETRIN DERMATOLOGY

PATIENT REGISTRATION FORM

PATIENT INFORMATION		
First Name:	Last Name:	Middle Initial:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Email:
Would you like access to your electronic medical record? (circle one) YES NO		
☐M ☐F Marital Status (circle): S M D W	Date of Birth:	SSN#:
Race (Circle one): -White -Black or African American - American Indian or Alaska Native - - Asian - Native Hawaiian or Other Pacific Islander –		
Ethnicity (circle one): Hispanic or Latino - Not Hispanic or Latino	Preferred Language:	
Parent/Guardian Name (If applicable):	Date of Birth:	
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		
PRIMARY INSURANCE INFORMATION		
Subscriber Name:	Date of Birth:	Relationship:
Subscriber Address: (If different from patient)		
SECONDARY INSURANCE INFORMATION		
Subscriber Name:	Date of Birth:	Relationship:
Subscriber Address: (If different from patient)		
IN CASE OF EMERGENCY		
Name of nearest friend or relative (not living with you):		
Relationship to patient:	Phone Number: ( )	
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/Parent or Guardian signature	**Date**	

Patient Name:_____Today's Date:____/____/____

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physician.

Initials: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have and/or reviewed a copy of my physicians Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices)

Initials: _____

Person to be notified in case of emergency

Name_____Relationship_____

Phone #_____

Please list the names of family member or friend (s) who are authorized to receive health care information about you if you are not available:

Name:_____Phone:_____Relationship:_____
_____All Medical Records _____Labs/X-rays/Pathology _____Other (Specify_____)

Name:_____Phone:_____Relationship:_____
_____All Medical Records _____Labs/X-rays/Pathology _____Other (Specify_____)

Name:_____Phone:_____Relationship:_____
_____All Medical Records _____Labs/X-rays/Pathology _____Other (Specify_____)

May we leave a detailed message on a voicemail, answering machine, or with another person regarding an appointment, lab/biopsy results, or other medical concerns?

Yes_____ No_____ Best Number to Leave Message:_____

How did you hear about us?

- ❑ Newspaper Article
- ❑ Phonebook:
- ❑ Website Search
- ❑ Word of Mouth
- ❑ Other_____

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 my health insurance plan. **I understand that all fees are my responsibility,** and I will pay Petrin Dermatology the full amount due 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 of 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 of a minor when not brought in by their parent. This allows others such as grandparents, older siblings, as you specify to bring the minor in for treatment.

APPOINTMENT CANCELLATION: We require 24-hour notice for appointment cancellations. 2 or more missed appointments will result in a **$40.00 no show fee or discharge from the practice.**

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 a lack of necessary billing information, you may be required to reschedule the appointment for a time when 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: _____

Why are you being seen today?

_____

PAST MEDICAL HISTORY: (Please circle all that apply)

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

HAVE YOU HAD ANY SURGERIES ON THE FOLLOWING ORGANS? (Please circle all that apply)

Appendix	Joint Replacement: Hip (Both)	Skin: Basal Cell
Bladder (Cystectomy)	Joint Replacement: Hip (Left)	Skin: Melanoma
Breast Biopsy	Joint Replacement: Hip(Right)	Skin: Squamous Cell
Breast: Lumpectomy (Both)	Joint Replacement: Knee (Both)	Spleen
Breast: Lumpectomy (Right)	Joint Replacement: Knee (Left)	Testicles
Breast: Lumpectomy (Left)	Joint Replacement: Knee (Right)	Uterus (Hysterectomy): Fibroids
Breast: Mastectomy (Both)	Kidney Stone Removal	Uterus (Hysterectomy): Uterine
Breast: Mastectomy (Right)	Kidney Transplant	Cancer
Breast: Mastectomy (Left)	Kidney: Nephrectomy	Uterus (Hysterectomy): Cervical
Colon: Colectomy (Colon Cancer)	Liver: Hepatectomy	Cancer
Colon: Colectomy (Diverticulitis)	Liver Transplant	
Colon: Colectomy (IBS)	Liver Shunt	Other:
Colon: Colostomy	Ovaries: Endometriosis	_____
Gallbladder	Ovaries: Ovarian Cancer	
Heart: Biological Valve Replacement	Ovaries: Ovarian Cyst	
Heart: Coronary Artery Bypass	Ovaries: Tubal Litigation	
Heart: Heart Transplant	Pancreas: Pancreatectomy	
Heart: Mechanical Valve Replacement	Prostate Biopsy	**NONE**
Heart: PTCA	Prostate Cancer	
	Prostate TURP	

SKIN DISEASE HISTORY: (Please circle all that apply)

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

PREFERRED PHARMACY_____

LOCATION_____

Why are you being seen today?

_____

Do you wear sun screen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have family history of **Melanoma** (life threatening type of skin cancer) Yes No
If yes, which relative(s)? _____

Please list all current medications:

_____
_____
_____
_____

Please list all drug allergies:

_____
_____
_____
_____

SMOKING STATUS (Please circle all that apply)

Current every day smoker
Current someday smoker
Former smoker
Never smoker

SOCIAL HISTORY DETAILS (Please circle all that apply)

Not sexually active	EtOh **(alcohol consumption)**
Sexually active with one partner	EtOh none
Sexually active with more than one partner	EtOh less than one drink per day
Same sex partner	EtOh 1-2 drinks per day
	EtOh 3 or more drinks per day
Drug use	
Iv drug use	Patient feels safe at home
	Patient feels unsafe at home

Review of Systems: Are you currently experiencing any the following? (Please circle all that apply)

Problems with bleeding	Depression	Pacemaker
Problems with healing	Fever or chills	Defibrillator
Problems with scarring	Headaches	Artificial joints within past 2 years
Immunosuppression	Hay fever	Artificial heart valve
Changing mole	Joint aches	Premedication prior to procedures
Rash	Muscle weakness	Allergy to adhesive
Abdominal pain	Neck stiffness	Allergy to topical antibiotic ointment
Anxiety	Night sweats	Blood thinners
Bloody stool	Seizures	Pregnant or planning a pregnancy
Bloody urine	Shortness of breath	Allergy to lidocaine
Blurry vision	Sore throat	Rapid heartbeat with epinephrine
Chest pain	Thyroid problems	Yeast infections with antibiotics
Cough	Unintentional weight loss	GI upset with antibiotics
	Wheezing	