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, 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: _____

Patient Name_____

Why are you being seen today? _____

Were you sent here by your doctor? Y or N

Physician that sent you _____ **Clinic Phone #**_____

Pharmacy Name and Location: _____

History and Intake Form

Past Medical History: (please circle all that apply)

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

Other _____

Past Surgical History: (please circle all that apply)

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

Patient Name_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
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

Other

_____

_____

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** (life threatening type of skin cancer) Yes No
If yes, which relative(s)?

_____

Medications: (Please enter all current medications)

_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____
_____

Social History: (Please circle all that apply)

Not sexually active
Sexually active with one partner
Sexually active with more than one partner
Same sex partner

Drug Use
IV Drug Use

EtOH (alcohol consumption)
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Patient feels safe at home
Patient feels unsafe at home

Other_____

Smoking Status: (Please circle all that apply)

Unspecified
Current every day smoker
Current some day smoker
Former smoker
Never smoker
Smoker current status unknown
Unknown if ever smoked

Patient Name_____

Review of Systems: Are you **currently** experiencing any of the following?
(Please circle yes for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Immunosuppression		
Changing mole		
Rash		
Abdominal Pain		
Anxiety		
Bloody Stool		
Bloody Urine		
Blurry Vision		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Wheezing		
Pacemaker		
Defibrillator		
Artificial Joints within past 2 years		
Artificial Heart Valve		
Premedication prior to procedures		
Allergy to adhesives		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or Planning a Pregnancy		
Allergy to lidocaine		
Rapid heartbeat with epinephrine		
Yeast infections or GI upset with antibiotics		