NEW PATIENT REGISTRATION
(PLEASE PRINT CLEARLY)

Today's Date ______________________

Name____
First M.I. Last

SSN____________________________ Date of Birth________________________ Age______ Sex M/F

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Race ____________________ **Ethnicity** (Hispanic/Non-Hispanic, Latino/Non-Latino)

Mailing Address ____
City State Zip

Home Phone ______________________________**Alternative Phone**_________________________________

E-mail Address____

Would you like to receive emails (Inclement Weather, Announcements, Specials and Promotions) from us?
Yes/No

Occupation/Work Place____

Reason for visit ____

Clinical Quality Measures: Height______________ Weight_____________________

HOW DID YOU HEAR ABOUT US?

☐ Family Member/Friend, if yes, who? _____________________________________
☐ Our Website
☐ Social Media, if yes, which site? ____
☐ Insurance
☐ Magazine/TV/Other Media (please indicate which one) ____
☐ Another Physician's Office (please indicate name/address) ____

EMERGENCY CONTACT

Name ____
First M.I. Last

Home Phone________________ **Work Phone**__________________ **Cell Phone**______________________

Relationship to Patient__________________________________

PRIMARY/SECONDARY INSURANCE COVERAGE

Primary Insurance Carrier ______________________ID# _____________________GROUP#_________________

Secondary Insurance Carrier___________________ ID# ______________________GROUP# _________________

Name of Policy Holder (insured person) __________________________ Relationship to Patient _______________

Policy Holder Date of Birth _______________________

PLEASE REVIEW AND SIGN THE FOLLOWING

Payment Policy: The Parent/Guardian will be responsible for ALL copayments, we will not forward bills to other parties regardless of court rulings or divorce decrees.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please Sign So We May Have Your Medicare Authorization/ Supplemental Authorization On File:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

If you call the office and request any information from your medical chart (test results, etc.) you will be required to provide the last four digits of your Social Security # before any information can be discussed. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. For those patients, applicable co-payments and deductibles will be collected. In the event that your account must be turned over to collections, the patient responsibility is the actual cost of collections including but not limited to court/attorney fees.

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).
I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims. A copy of this authorization may be used in the place of the original. I understand and agree that I am financially responsible for all charges not paid by my insurance company. While we may participate with your insurance plan, it is your responsibility to be aware of your out of network insurance benefits. This authorization may be revoked by either me or my insurance carrier at any time in writing.

IF YOU NEED TO RESCHEDULE OR CANCEL AN APPOINTMENT, PLEASE NOTIFY US AT LEAST 48 HOURS IN ADVANCE, OR YOU MAY BE SUBJECT TO A $25 LATE CANCELLATION FEE FOR STANDARD OFFICE VISITS AND/OR $50 FEE FOR PROCEDURE AND COSMETIC VISITS. IF A FEE IS INCURRED, YOU WILL BE MAILED A STATEMENT REFLECTING THE CHARGE. YOUR SIGNATURE BELOW SIGNIFIES YOUR UNDERSTANDING AND WILLINGNESS TO COMPLY WITH THIS POLICY.

I have read and given a copy (If PT asked) of the HIPAA Notice of Privacy Act and Patient Rights.
Renascance Dermatology may call AND/OR mail to my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or other healthcare operations. By signing this form, I am consenting to Renascance Dermatology’s use and disclosure of my protected health information and any fees to carry out treatment, payment and other healthcare operations.

________________________________ ________________________________

Signature of Patient or Legal Guardian **Date**

Please list below any person(s) and their relation to you that you authorize our office to speak with regarding your health care.

1.____ Relation______________________________

2.____ Relation______________________________

3.____ Relation______________________________

4.____ Relation______________________________

PHARMACY

Pharmacy Name____

Address____

State Zip

Phone/Fax____

MEDICATIONS

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MEDICATION ALLERGIES

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Past Medical History

__Anxiety
__Arthritis
__Artificial Joints
__Asthma
__Atrial Fibrillation
__BPH (Benign Prostatic Hyperplasia)
__Bone Marrow Transplantation
__Breast Cancer
__Colon Cancer
__COPD (emphysema)
__Coronary Artery Disease
__Depression
__Diabetes
__End Stage Renal Disease
__Gerd (Acid Reflux)
__None
__Hearing Loss
__Hepatitis
__Hypertension
__HIV/AIDS
__Hypercholesterolemia
__Leukemia
__Lung Cancer
__Lymphoma
__Pacemaker
__Prostate Cancer
__Radiation Treatment
__Rosacea
__Seizures
__Stroke
__Valve Replacement

Other________________________________

Past Surgical History

__Appendix Removed
__Bladder Removed
__Breast: Mastectomy (right, left, bilateral)
__Breast: Lumpectomy (right, left, bilateral)
__Breast Reduction
__Breast Implants
__Colectomy: Colon Cancer Resection
__Colectomy: Diverticulitis
__Colectomy: IBD
__Colon: Colostomy
__Gallbladder Removed
__Heart: Coronary Artery Bypass
__Heart: PTCA
__Heart: Mechanical Valve Replacement
__Heart: Biological Valve Replacement
__Heart Transplant
__Hysterectomy: Fibroids
__Hysterectomy: Uterine Cancer
__Joint Replacement Hip (right, left, bilateral)
__Joint Replacement Knee (right, left bilateral)
__Kidney Biopsy
__Kidney Stone Removal (right, left)
__Kidney Transplant
__Kidney: Nephrectomy
__Ovaries Removed: Endometriosis
__Ovaries Removed: Cyst
__Ovaries Removed: Ovarian Cancer
__Ovaries: Tubal Ligation
__ Pancreas: Pancreatectomy
__Prostate Removed: Prostate Cancer
__Prostate Biopsy
__TURP
__ Rectum: APR
__Rectum: Low Anterior Resection
__Melanoma Surgery
__Skin Biopsy
__Squamous Cell Carcinoma
__Spleen removed
__Testicles Removed (right, left, bilateral)
__None

Other________________________________

Skin Disease History

__Acne
__Actinic Keratoses
__Asthma
__Basal Cell Skin Cancer
__Blistering Sunburns
__Dry Skin
__Eczema
__Flaking/Itchy Scalp
__Hay Fever/Allergies
__Melanoma
__Poison Ivy
__Precancerous Moles
__Psoriasis
__Squamous Cell Skin Cancer
__None
__Other____________________________

Review of Body History

Y/N Problems with Bleeding
Y/N Problems with Healing
Y/N Problems with Scarring (hypertrophic or keloid)
Y/N Rash
Y/N Immunosuppression
Y/N Hay Fever
Y/N Night Sweats
Y/N Unintentional Weight Loss
Y/N Cough
Y/N Wheezing
Y/N Anxiety
Y/N Sore Throat
Y/N Thyroid Problems
Y/N Blurry Vision
Y/N Abdominal Pain
Y/N Bloody Stool
Y/N Bloody Urine
Y/N Joint Aches
Y/N Muscle Weakness
Y/N Neck Stiffness
Y/N Fever or Chills
Y/N Headaches
Y/N Seizures
Y/N Shortness of Breath
Y/N Depression

Social History

Smoking
Smoker/Non Smoker/Former

Alcohol Use
Yes/No

Language
English/Spanish/Other

Do You Wear Sunscreen?
Yes What SPF? __________
No

Do You Tan In A Tanning Salon?
Yes/No

How Often Do You Exercise?
Once a day
A few times a week
A few times a month
Never

What Is Your Caffeine Use?
Once a day
A few times a week
A few times a month
Never

Do You Drive? Y/N

Do You Feel Safe at Home? Y/N

Do you have a family history of Melanoma? Y/N

Yes/ Which Relatives____

Any other family history____