REGISTRATION FORM

(Please Print Clearly)

Today's date:	**Reason for visit:**		
How did you hear about us?: ❑ Friend ❑ Insurance ❑ Internet ❑ Doctor:			❑ Other:
Primary Care Physician		**Specialist Physician:**	

PATIENT INFORMATION

Patient's last name:	MI:	First:	DOB:
Preferred Name:		Email:	
Street address: P.O. box (if preferred):	Social Security no.: City:	Preferred Contact No.: State & Zip Code:	
Mobile No.:	Work No.:	Home No.:	
Occupation:	Employer:	Employer phone no.:	

GUARANTOR OR RESPONSIBLE PARTY

(Patient is Responsible Party if OVER 18 years of Age)
(Please give your insurance card to the receptionist.)

Responsible Party's Name:	DOB:	Address (if different):	Preferred Contact No.:
Is this person a patient here?	❑ Yes ❑ No		Relationship to Patient:

INSURANCE INFORMATION

Primary Insurance

Subscriber's name:	Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary Insurance

Subscriber's name:	Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other

Tertiary Insurance

Subscriber's name:	Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

Health Insurance Portability and Accountability Act (HIPAA)

I have been offered a copy of ATLANTA DERMATOLOGY & AESTHETICS, PC'S Notice of Privacy Practice.

Signature of Patient/Guardian: _____ **Date:** _____

AUTHORIZATION INFORMATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Atlanta Dermatology & Aesthetics, PC or insurance company to release any information required to process my claims.

Signature of Patient/Guardian: _____ **Date:** _____

Past Medical History (please CHECK all that apply):

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

N/A

OTHER: _____

Past Surgical History (please CHECK all that apply):

Appendix Removed
Bladder Removed
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
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, within last 2years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (prostate removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

N/A

OTHER: _____

Skin Disease History (please CHECK 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

N/A

OTHER: _____

Alerts (please CHECK all that apply):

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial Heart Valve
Artificial Joint Replacement
Blood Thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?

N/A

Patient Sun Protection

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

Family Medical History (immediate relatives <u>ONLY</u>):

_____

_____

_____

_____

Do you have a Family History of Melanoma? Yes No
If so, which relative?

_____
_____

Medications
(List current medication. if none, put N/A):

_____
_____
_____
_____

Allergies:
(incl. food, & seasonal. If none, put N/A)

_____
_____
_____
_____

Social History (please circle all that apply):

Cigarette Smoking:

Never Smoked

Currently Smokes

Has smoked in the past (socially)

Former Smoker

Alcohol Use:

NONE

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

Race: _____ **Ethnic Group**: _____

Pharmacy Information (Very Important)

Prescription(s) will be sent to your pharmacy electronically.

Pharmacy Name:

Pharmacy Phone No.:

Pharmacy Address:

Zip Code:

FINANCIAL POLICY

Welcome and thank you for choosing our practice. Our goal is to provide excellent care and superior patient service. Our policies printed below, will help us to better serve you.

Payment

- Our office accepts cash, personal checks, CareCredit, Visa, MasterCard, American Express, and Discover.
- If your insurance cannot be verified at the time of your visit, you may reschedule or be a Self-Pay patient.
- Co-payments are due at the time of service.
- **Co-insurance (deductible) Plans:** If your insurance plan does not require copayment and your deductible or out-of-pocket has not been met, you may receive a bill for your office visit. A deposit may be required prior to scheduling surgical procedures.
- Partial payment may be required when scheduling cosmetic procedures
- **Self-Pay:** New patients - $175 Established patients - $100. Procedure costs are quoted by the provider.
- **Refunds:** Our office does not issue refunds for services rendered or products (incl. in-office prescriptions) purchased. You can return the product to the office, and the amount may/will be credited to your account.

Insurance

- The patient is responsible for **ALL** in-network inquiries.
- To protect against fraud you MUST present your insurance card at each visit, and we REQUIRE a **government-issued** ID on file.
- We will file claims to your insurance carrier and accept payment directly from them. It is the patient's responsibility to keep us informed with up to date insurance coverage and contact information. **Patients are fully responsible for all costs denied by their insurance.**
- **It is your responsibility to know your insurance benefits. We can never guarantee insurance coverage for any service provided.**
- If your plan requires a referral or prior authorization to see the provider, it is your responsibility to obtain this prior to your visit.
- **MEDICARE PATIENTS:** If you are currently covered under Medicare, please present ALL insurance cards at the time of your visit. Medicare offers a *Medicare Advantage* plan in lieu of traditional Medicare. If you have chosen an Advantage plan and do not present the correct card, you will be responsible for any denied charges.

Labs

- Lab tests ordered through our office are billed separately by the lab to your insurance. Patients are responsible for any lab charges.
- If your insurance requires that tests be sent to a specific lab, **it is your responsibility to tell the Nurse**, not the front desk, at the time the test is ordered.

Collections

- Balances are due within 30 days of statement date.
- **Past due balances:** Outstanding balances are sent to a collections agency and your account with our practice may be closed.
- **BILLING COMPANY: West Coast Derm Billing (WCDB), 1-888-541-9232. Please call for any questions.**

Patients Under 18 Years Old

- The patient registration form must be signed and guaranteed by the legal guardian accompanying the minor at the first appointment. The "Responsible Party" is legally responsible for payment.

Phone Consultations

- For any extensive medical phone conversations or consultations with the providers, a billable code will be filed to your insurance which may or may not be covered by your insurance plan.

Fees

- **Confirmation calls** (made within 2 days of appointment) are considered a courtesy. We are not responsible for voicemails that are full and phone numbers that are disconnected. Patients are responsible for maintaining their appointment dates. To protect the practice, we must charge a "no show" fee for missed appointments. The fee is $50 for any **missed appointments and appointments cancelled or rescheduled** without a 24 hour notice.
- **Returned check fee:** You will be responsible for the full amount of any check returned from the bank for non-payment, in addition to a $35 check return fee.
- **Forms:** A fee of $35 is assessed for printed medical records, medical letters for work, school, legal proceedings, health insurance, and paperwork for life insurance and disability applications.

By signing this form, I am stating that I have read the information above and understand my financial responsibility for my account.

_____ _____

Patient Signature Date

ATLANTA
DERMATOLOGY & AESTHETICS

Today's Date: _____
First Name: _____ Middle Initial: _____ Last Name: _____
DOB: _____ Gender: M F Phone Number: _____
Marital Status: Single Married Widowed Divorced
Occupation:_____
With whom do you live?_____
Who is your primary care doctor?_____
Where is your primary care doctor located?
_____
Primary Care Phone Number: _____
Please provide a list of medications you take, INCLUDING supplements and occasional use (i.e. aspirin)
_____
_____

Do you have a history of Melanoma? Yes No **If yes**, list the date of diagnosis and details.

_____
_____

Please check the option below that reflects your wishes.

Do you smoke? Yes No
Did you get a pneumonia vaccine? Yes No
Did you have a Flu shot this year? Yes No
Did you have a Flu shot last year? Yes No

Please indicate Alcohol Use and Frequency
None
Occasional/Social: _____ drinks per month
Daily: _____ drinks per day

Do you have a Living Will? Yes No
Who is your Healthcare Proxy/Power of Attorney? _____

For patients 65 or older:

Advance Directives: I would like **(circle one)**…

- **Full Code:** full cardiopulmonary resuscitation efforts to be made for life saving measures.
- **Do Not Intubate: I DO NOT WISH** to have a breathing tube, even if it is required for life saving measures.
- **Do Not Resuscitate:** I do not wish to have chest compressions or an automated external defibrillator to restart the heart, even if it is required for life saving measures.

NOTE: Please be sure to give this document to the Nurse after it is completed.