ROSEVILLE DERMATOLOGY
Medical | Surgical | Cosmetic

PATIENT REGISTRATION

Please fax to 916.784.7548 or mail to us prior to your appointment

Name _____
Last First MI

Address _____
Street City State Zip

Telephone (____)_____(____)_____(____)_____ext_____
Home Cell Work

Primary care physician _____

Referred by _____

Date of Birth _____

Gender ❒ Male ❒ Female

Occupation _____

Employer _____

Marital Status ❒S ❒M ❒D ❒W

SSN _____

Emergency Contact _____
Last Name First Name

_____
Phone Number Relation (spouse, parent, etc)

INSURANCE INFORMATION *Please present your insurance card(s) to the receptionist*

❒ Self Pay (no insurance)

Primary Insurance Co _____

Relation to policyholder _____
(self, spouse, child, etc)

If patient is NOT the policyholder:

_____
Policyholder's Last Name First Name

_____
Policyholder's DOB Policyholder's SSN

Secondary Insurance Co _____

Relation to policyholder _____
(self, spouse, child, etc)

If patient is NOT the policyholder:

_____
Policyholder's Last Name First Name

_____
Policyholder's DOB Policyholder's SSN

Email _____

Race ❒Decline to report ❒American Indian or Alaska Native ❒Asian ❒Native Hawaiian or Other Pacific ❒Black or African American ❒White ❒Hispanic ❒Other Race _____

TELEPHONE INFORMATION and COMMUNICATION RELEASE

May we leave medical information on your *home* answer machine? ❒ Yes ❒ No
May we leave medical information on your *cell* voicemail? ❒ Yes ❒ No
May we discuss your medical information with family members? ❒ Yes ❒ No
If yes, please list: _____

REFERRAL INFORMATION

❒ Physician _____ ❒ Internet ❒ Other _____
❒ Family/Friend _____ ❒ Phone books (Yellow pages)

Signature _____ **Date**_____

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MEDICAL QUESTIONNAIRE

Please fax to 916.784.7548 or mail back to us PRIOR to your appointment

Name _____
Last First MI

Reason for today's visit _____

How long have you had this problem? _____

Symptoms (how does it bother you?) _____

Treatments you have tried _____

Current Medications – include prescriptions, over-the-counter meds (such as aspirin), vitamins, and herbal products:

_____

_____

ALLERGIES to any medications? ❒ None ❒ Yes _____
List name of medication and type of reaction

Pharmacy of choice _____
Name Street name City

MEDICAL HISTORY: *Check below if you have or ever had any of the following diseases*

❒ Artificial heart valve	❒ Cancer _____	❒ High blood pressure	❒ Stroke
❒ Artificial joint	❒ Depression	❒ Kidney disease	❒ Thyroid disease
❒ Asthma	❒ Diabetes	❒ Liver disease/Hepatitis	❒ Other _____
❒ Bleeding disorder	❒ Hayfever/seasonal allergies	❒ Lung disease	
❒ Blood clots	❒ Heart disease	❒ Pacemaker	

SKIN HISTORY

Have you had **skin cancer**? ❒ Yes ❒ No
If Yes, ❒ Melanoma ❒ Basal cell carcinoma ❒ Squamous cell carcinoma ❒ Yes, but don't know type
Locations: _____
Treatments/Surgeries and Date: _____

Do you have a history of any specific skin diseases? ❒ Yes ❒ No
If yes please list, _____

When you are exposed to sunlight, do you:

❒ *always* burn (skin type 1)	❒ *often* burn, tan *slowly* (3)	❒ *rarely* burn, *always* tan (5)
❒ *usually* burn, *rarely* tan (2)	❒ *sometimes* burn, tan *well* (4)	❒ *never* burn, *deeply* tan (6)

Women only:

Are you pregnant? ❒ Yes ❒ No Are you breastfeeding? ❒ Yes ❒ No Are you trying to conceive? ❒ Yes ❒ No

FAMILY HISTORY: *Please list any blood relative (parents, grandparents, siblings, and children) with a history of:*

❒ Skin Cancer _____ ❒ Melanoma _____

SOCIAL HISTORY

Do you drink alcohol? ❒ Yes ❒ No: If yes, _____ drinks/week Do you smoke? ❒ Yes ❒ No: If yes, ____ packs/day

Have you recently had any of the following? REVIEW OF SYSTEMS (ROS)

❒ Allergy symptoms	❒ Hair loss	❒ Menstrual problems	❒ Shortness of breath
❒ Bleeding problems	❒ Heat/cold intolerance	❒ Palpitations	❒ Swollen lymph node
❒ Depression	❒ Joint pain	❒ Rash	❒ Weight change

I certify that the above information, to the best of my knowledge, is correct.

Signature _____ **Date** _____

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Name _____ Date of Birth _____

FINANCIAL POLICY

1. **We request a 24 hour cancellation notice.** Failure to cancel an office visit will result in a $25 fee. Failure to cancel a surgical or cosmetic procedure will result in a $75 fee.

2. **Payment is due at the time of service.** It is your responsibility to pay for any deductibles, co-payments, or non-covered/cosmetic services on the day of your appointment. We accept Visa, MasterCard, debit, checks, and cash. There is a $25 charge for checks returned for insufficient funds.

3. Keep in mind that your insurance policy is basically a contract between you and your insurance company. However, you are ultimately responsible for the payment of services. As a service to you, we will file your insurance claim if you assign the benefits to the doctor–in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you are responsible for paying any outstanding balances.

4. If we are not contracted with your insurance carrier or if you do not have insurance coverage, you are responsible for payment in full at the time of service.

5. Not all insurance plans cover all services. Although policies vary among insurance companies and plans, most do not cover cosmetic services or removal of benign skin growths. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge.

AUTHORIZATIONS

1. I have read and understand the practice's financial policy and I agree to be bound by its terms.
2. 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 and prescriptions.
3. I have read and understand the Notice of Privacy Practices from Roseville Dermatology, Inc.
4. I authorize Roseville Dermatology, Inc. to take digital photographs for my medical record only if medically necessary.
5. I authorize my providers and staff here to view my external prescription history via the RxHub service.

Signature: _____ Date: _____