PATIENT REGISTRATION

Name ____
Last First MI Preferred Name

Address ____
Street City State Zip

Telephone (____)______________ (____)______________ (____)______________ext_____
Home Cell Work

Date of Birth ______________________

Emergency Contact ______________________
Last Name First Name

____
Phone Number Relation (spouse, parent, etc)

Marital Status ❒S ❒M ❒D ❒W

Primary Care Physician ______________________

Email ______________________________________ ❒ Opt in to monthly newsletter email

TELEPHONE INFORMATION and COMMUNICATION RELEASE

May we leave medical information on your voicemail? ❒ Yes ❒ No
May we discuss your medical information with family members? ❒ Yes ❒ No

If yes, please list name(s): ____

REFERRAL INFORMATION

❒ Physician______________________ ❒ Internet ❒ Other______________________
❒ Family/Friend____________________ ❒ Phone books (Yellow pages)

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

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?

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

Name ______________________________ Date of Birth ____________________

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

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: ____________________