



PATIENT REGISTRATION

Name Last First MI Preferred Name

Address Street City State Zip ext

Telephone Home Cell Work

Date of Birth Emergency Contact Last Name First Name

Social Security # Phone Number Relation (spouse, parent, etc)

Marital Status S M D W Primary Care Physician

Gender Male Female Other

Email Opt in to monthly newsletter email

Occupation/Employer

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:

REASON FOR VISIT

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?

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



Name _____		Date of Birth _____	
INSURANCE INFORMATION <i>Please present your insurance card(s) to the receptionist</i> <input type="checkbox"/> Self Pay (no insurance)			
Primary Insurance Co _____		Secondary Insurance Co _____	
Relation to policyholder _____ <small>(self, spouse, child, etc)</small>		Relation to policyholder _____ <small>(self, spouse, child, etc)</small>	
If patient is NOT the policyholder:		If patient is NOT the policyholder:	
Policyholder's Last Name _____	First Name _____	Policyholder's Last Name _____	First Name _____
Policyholder's DOB _____	Policyholder's SSN _____	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:** _____