Advanced Dermatology

Registration (Please Print)

Date _____ Cell Phone _____ Home Phone _____

Name _____ Name you prefer to be called _____
Last First Middle

Address _____
City State Zip

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Social Security #_____ Whom may we thank for referring you? _____

Preferred Language:_____ Race & Ethnic Group:_____

Employer _____ Work Phone _____
Name Address

Occupation_____ If Student: ❑ Part-time ❑ Full-time Email Address _____

In case of emergency, who should be notified? _____ Phone _____

Do we have permission to: Leave a message on your answering machine? ❑ Yes ❑ No
Leave a message at your place of employment? ❑ Yes ❑ No
Discuss your medical condition with any member of your household? ❑ Yes ❑ No

If yes, Whom: _____ Relationship: _____

Person responsible for account (information <u>required</u> if patient is a minor):

_____
Name Address City State Zip

Insurance Company_____Policyholder_____

Policyholder Employer_____ Policyholder Social Security #_____

Patient relationship to Policyholder: ❑ Self ❑ Child ❑ Spouse ❑ Other Policyholder Date of Birth _____

In order to establish optimal relations with our patients and avoid any misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR YOUR PART OF THE CHARGES. We accept VISA, MasterCard, American Express and Discover for your convenience.

If we are participating providers for your insurance company, we will file your claim. However, any unmet deductible or co-pay is due at the time of service. <u>Please be aware that "Co-Pays" usually cover office visits.</u> <u>Surgical procedures usually fall under your deductible.</u> If we do not "participate" with your insurance company, you will be given a statement of office services which should be sent (along with your insurance form) to your insurance company so you may be reimbursed directly.

Please notify us at least two business days in advance if you are unable to keep your appointment. This courtesy allows someone else to be treated - a courtesy you would want if the circumstances were reversed.

Your signature below indicates that you understand and accept these policies. In addition, your signature certifices that you understand that you are financially responsible for all charges whether or not paid by insurance. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor, when an assigned claim is filed.

_____ _____ Circle One: Self Parent Guardian
Signature of Patient or Legal Guardian Date

_____
Print Name

A GUARDIAN OR ADULT SIGNATURE IS REQUIRED IF PATIENT IS UNDER AGE 18

Please present your insurance cards and photo ID to our receptionist. She will make copies and return them to you promptly.

Name:_____ DOB_____ Date:_____

Circle All That Apply

Bleeding Problems Yes No

Healing Problems Yes No

Scarring Yes No

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Do you have allergy to adhesive? Yes No

Do you have a reaction to lidocaine (local anesthetic injection)? Yes No

Do you experience rapid heartbeat with epinephrine (in local anesthetic injections)? Yes No

Are you allergic to any topical antibiotic ointments? Yes No If so, what:_____

Have you ever had MRSA (staph infection)? Yes No

Have you ever had difficulty stopping bleeding? Yes No

Are you on any blood thinners? Yes No

Do you have a defibrillator? Yes No

Do you have a pacemaker? Yes No

Do you have an artificial heart valve? Yes No

Have you had an artificial joint replacement within the past two years? Yes No

If yes, when and what body locations:_____

Do you require antibiotics prior to a surgical procedure? Yes No

Are you pregnant or currently trying to get pregnant? Yes No

Are you breastfeeding? Yes No

Have you traveled to West Africa or had contact with anyone who has? Yes No

Immunization History

Flu Vaccine: Yes No If yes, what year?_____

Pneumonia Vaccine: Yes No If yes, what year? _____

Zostavax (Shingles)? Yes No If yes, what year? _____

PATIENT SIGNATURE:_____ **DATE**_____

Name:_____ DOB_____ Date:_____

Smoking Status: **Circle All That Apply**

Every Day Smoker

Occasional Smoker

Former Smoker

No History of Smoking

If yes, heavy or light?_____

Cigarettes Cigar Other Tobacco

Sexually Active: **Circle All That Apply**

Not sexually active

Sexually active with one partner

Sexually active with more than one partner

Same gender partner

Alcohol Use: **Circle All That Apply**

No History of Alcohol Use

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

In the past year, have you had 2 or more days, that you have had greater than 4 drinks in one day?

Yes No

ILLEGAL Drug Use: **Circle All That Apply**

Current Drug Use Yes No

History of IV Use Yes No

IV use within the past 12 months

Driving Status: **Circle All That Apply**

Drive at night

Drive during the day

Exercise: **Circle All That Apply**

Never

Once a day

Several times per day

Few times per week

Few times per month

Name:_____ DOB_____ Date:_____

History of Skin Disease **Circle All That Apply**

NO SKIN DISEASE HISTORY	Autoimmune Disease	Hay Fever/Allergies	Precancerous Moles
Acne	Basal Cell Skin Cancer	Melanoma	Squamous Cell Skin Cancer
Actinic Keratoses	Blistering Sunburn	Psoriasis	
Asthma	Eczema	Poison Ivy	

Please Circle Response

Do you wear sunscreen?	Yes	No	If yes, what SPF? _____
Do you have a history of tanning bed use?	Yes	No	
Do you have a family history of Melanoma?	Yes	No	If yes, list relative:_____

Medication List: **Please provide all medication including dosages & prescribed frequency. Also please include over the counter medications, vitamins, supplements. Please ask for additional paper if needed from receptionist.**

NONE or list below

MEDICATION	DOSAGE AND FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medication:

NONE or list below

MEDICATION	REACTION
_____	_____
_____	_____

Laurie H. Harrington, MD **Advanced Dermatology** Kristen Hebert, PA

Patient Name:_____ **DOB:** _____

Preferred Pharmacy:_____ **Pharmacy City:**_____

Referral Physician:_____ **Pharmacy Zip Code:**_____

Primary Care Physician:_____

Past Medical History: Circle All That Apply

NO PAST MEDICAL HISTORY		HIV/AIDS	Stroke
Anemia	Depression	Irregular Heart Rhythm	Stomach Ulcers
Anxiety	Diabetes	Kidney Disease	Thyroid Disease (Hyper)
Arthritis	GERD (acid reflux)	Leukemia	Thyroid Disease (Hypo)
Asthma	Hearing Loss	Lung Cancer	Tuberculosis
Breast Cancer	Heart Disease	Lymphoma	
BPH(prostate enlargement)		Organ Transplant	
Chemotherapy	Hepatitis	Prostate Cancer	
Colon Cancer	High Blood Pressure	Radiation Treatment	
Coronary Artery Disease	High Cholesterol	Seizures	

Past Surgical History

NONE or list below

_____

_____