THE DERMATOLOGY CLINIC
OF ARKANSAS

PATIENT REGISTRATION FORM

(Please present insurance/government issued photo ID card to receptionist)

Patient Name: _____ _____ _____
First *Middle* *Last*

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home: ( ) _____ **Work:** ( ) _____ **Cell:** ( ) _____

Social Security Number: _____ **Date of Birth:** _____ / _____ / _____

PLEASE CIRCLE BELOW:

SEX: *Male or Female*

RACE: *American Indian/Alaskan Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander, Other, White, Declined*

ETHNICITY: *Hispanic/Latino, Not Hispanic/Latino, Other, Declined*

Language: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ Phone or zip Code: _____

RESPONSIBLE PARTY NAME AND ADDRESS (if other than the patient)

Name: _____ Social Sec. #: _____
Address: _____ City: _____ State: _____
Employer: _____ Work Phone: _____
Driver's License Number: _____

The following section applies if you are NOT the policy holder

Primary Insurance Name: _____
Policy Number: _____ Group Number: _____
Policy Holder's Name: _____
Social Security #: _____ Date of Birth: _____ / _____ / _____

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. ***Please Check:*** ❒ **Medicare** ❒ **Medicaid** ❒ **Private Insurance**

X _____ _____
Patient/ Guardian Signature Date

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office.

Payment is required in full for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payment and deductibles will be collected.

Any unpaid balance, after insurance payment, is due from the patient. Since our relationship is with the patient, the bill is the patient's responsibility. The patient will receive a monthly statement any time there is a balance on the patient's account that is considered patient responsibility. **If the entire balance cannot be paid in full, our business office can arrange a payment plan for the patient.**

Co-pays are due at the time of treatment. These amounts vary depending upon which managed health care plan the patient may have.

Payments Accepted: Cash, Check, VISA, MasterCard, Discover, or American Express.

There is a $25.00 charge to the patient for returned checks due to insufficient funds or closed accounts.

We accept Medicare assignment and participate in a number of HMO's, PPO's and other managed care plans. We must have a copy of the patient's insurance card and all insured party information including date of birth and social security number to process the claim.

Financing options are available through CareCredit Please inquire at checkout.

MEDICAL RECORDS

Patient fee for copying of records is $.50 per page for the first 25 pages, and $.25 per page thereafter. Please review your Explanation of Benefits from your insurance carrier.

If you have any questions or feel you are due a refund from The Dermatology Clinic, please contact our billing office at (501) 623-3400. We are always willing to be of assistance to you.

Your signature below signifies your understanding and willingness to comply with this policy.

_____ _____

Patient Signature Date

THE DERMATOLOGY CLINIC
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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health Information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations;
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice;
- The Practice reserves the right to change the Notice of Privacy Policies;
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions;
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease;
- The Practice may condition treatment upon the execution of this Consent.
- The Practice has an updated Notice of Privacy Practices.

Patient was offered the HIPAA Notice of Privacy Form: ❒ **Accepted** ❒ **Refused**

Do we have your permission to?

Leave a message on your home answering machine? ❒ Yes ❒ No ❒ N/A
Leave a message at your place of employment? ❒ Yes ❒ No ❒ N/A
Discuss your medical condition with any member of your household? ❒ Yes ❒ No ❒ N/A

(If yes, with whom: _____ Relationship: _____)

_____ _____
Patient / Representative Signature Date

_____ _____
Relationship to Patient Date

Witnessed By: _____ _____
(Print Name) (Signature)

THE DERMATOLOGY CLINIC
OF ARKANSAS

History and Intake Form

NAME: _____ **DATE OF BIRTH:**____/____/____

Past Medical History: (please **circle** all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other_____

Past Surgical History: (please **circle** 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
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
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
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

THE DERMATOLOGY CLINIC OF ARKANSAS

Skin Disease History: (please **circle** 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
None
Other _____

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

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all **current** medications)

_____
_____
_____
_____
_____
_____
_____

Allergies: (Please enter all **MEDICATION** allergies)

_____
_____
_____
_____
_____
_____
_____

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Social History: (Please **circle** one)

Cigarette Smoking: (13 and Older)
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
YES
NO

Language:
English
Spanish
Other: _____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Driving Status:
Drives in the Daytime
Drives at Night

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

Occupation and Workplace: _____

Residence/Facility: _____

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REVIEW OF SYSTEMS

New / Referred Patient

Problems with Healing	**Yes**	**No**
Problems with Scarring	**Yes**	**No**
Rash	**Yes**	**No**
Photosensitivity	**Yes**	**No**
Nodules / Other Types of Lesions	**Yes**	**No**
Fever Blisters / Oral Herpes Infections	**Yes**	**No**
Genital Lesions	**Yes**	**No**
History of Shingles	**Yes**	**No**
Problems with Bleeding	**Yes**	**No**
Swollen / Tender Lymph Nodes	**Yes**	**No**
Immunosuppression	**Yes**	**No**
Hay Fever	**Yes**	**No**
Chest Pain	**Yes**	**No**
Palpitations	**Yes**	**No**
Fever or Chills	**Yes**	**No**
Frequent Infections	**Yes**	**No**
Fatigue / Malaise	**Yes**	**No**
Night Sweats	**Yes**	**No**
Unintentional Weight Loss	**Yes**	**No**
Unintentional Weight Gain	**Yes**	**No**
Thyroid Problems	**Yes**	**No**
Blurry Vision	**Yes**	**No**
Abdominal Pain	**Yes**	**No**
Nausea / Vomiting	**Yes**	**No**
Constipation / Diarrhea	**Yes**	**No**
Bloody Stool	**Yes**	**No**
Bloody Urine	**Yes**	**No**
Menopause	**Yes**	**No**
Joint Aches	**Yes**	**No**
Muscle Weakness	**Yes**	**No**
Neck Stiffness	**Yes**	**No**
Arthritis	**Yes**	**No**
Headaches	**Yes**	**No**
Seizures	**Yes**	**No**
Cough	**Yes**	**No**
Shortness of Breath	**Yes**	**No**
Wheezing	**Yes**	**No**
Anxiety	**Yes**	**No**
Depression	**Yes**	**No**
Insomnia	**Yes**	**No**
Fear of Cancer	**Yes**	**No**
Sore Throat	**Yes**	**No**
Thrush	**Yes**	**No**

REVIEW OF SYSTEMS

New / Referred Patient

Blood Thinners	**Yes**	**No**
Aspirin	**Yes**	**No**
Pacemaker	**Yes**	**No**
Defibrillator	**Yes**	**No**
Artificial Heart Valve Within Last Two Years	**Yes**	**No**
Rapid Heartbeat With Epinephrine	**Yes**	**No**
Allergy to Lidocaine	**Yes**	**No**
Allergy to Adhesive	**Yes**	**No**
Allergy to Latex	**Yes**	**No**
Allergy to Topical Antibiotic Ointment	**Yes**	**No**
Premedications Prior to Procedures	**Yes**	**No**
Pregnancy or Planning a Pregnancy	**Yes**	**No**
MRSA	**Yes**	**No**
HIV	**Yes**	**No**
Hepatitis	**Yes**	**No**

_____ _____ / _____ / _____

Patient Name Date of Birth