THE DERMATOLOGY CLINIC
OF ARKANSAS

501.623.6100 Ph#
866.511.3376 T.F.#
501.623.6187 Fax#

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: _____ **D.O.B.** _____ / _____ / _____

Place of Birth (City & State) _____ **Email:** _____

Would You Like To Receive Text Message Reminders For Future Appointments? ☐ Yes ☐ No

SEX:	☐ Male ☐ Female
RACE:	☐ American Indian ☐ Asian ☐ Black/African American ☐ Other ☐ White ☐ Declined
ETHNICITY:	☐ Hispanic-Latino ☐ Not Hispanic-Latino ☐ Other ☐ Declined
MARITAL STATUS:	☐ Married ☐ Divorced ☐ Single ☐ Widowed

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: _____
D.O.B. _____ / _____ / _____

The following section applies if you are <u>NOT</u> the policy holder

Primary Insurance Name: _____
Policy Number: _____ Group Number: _____
Policy Holder's Name: _____
Social Security #: _____ D.O.B. _____ / _____ / _____

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

N

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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) 623-6100. We are always willing to be of assistance to you.

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

X_____ _____

Patient Signature Date

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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.

Your signature consents to use and disclosure of your protected health information for treatment, payment & health care operations. You have the right to revoke this Consent, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Dermatology Clinic is in compliance 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.

Would you like a copy of the HIPAA Notice of Privacy Form? ❒ **Yes** ❒ **No**

Do we have your permission to:

Leave a message on your cell phone answering machine? ❒ Yes ❒ No ❒ N/A
Leave a message at your place of employment? ❒ Yes ❒ No ❒ N/A
Discuss your medical condition with anyone other than yourself? ❒ Yes ❒ No ❒ N/A
If yes, with whom:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

X_____ _____
Patient / Representative Signature Date

_____ _____
Representative Relationship to Patient Date

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HISTORY AND INTAKE FORM

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH (Benign Prostatic Hyperplasia)
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension
High Blood pressure
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

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 Implants
Breast Reduction
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colon: Colostomy
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
PTCA
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Removed
Liver Transplant
Liver Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Tubal Ligation
Pancreas Removed
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP (Prostate Removal)
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Squamous Cell Carcinoma
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids

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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

Other: _____

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

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

Medications: (Please enter all current medications, dosage and how often it is taken)

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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Social History (please circle one)

Cigarette Smoking:
Currently Smokes
Never smoked
Former Smoker

Language:
English
Spanish
Other: _____

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Driving Status:
Drives in the Daytime
Drives at Night

Race:
White
Black/African American
American Indian
Native Alaskan
Other: _____

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

Caffeine use
Once a day
A few times a week
A few times a month
Never

Alcohol Use:
None
less than 1 drink per **DAY**
1-2 drinks per **DAY**
3 or more drinks per **DAY**

Occupation and Workplace: _____

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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**
Sore Throat	**Yes**	**No**
Thrush	**Yes**	**No**

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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**
Premedication's Prior to Procedures	**Yes**	**No**
Pregnancy or Planning a Pregnancy	**Yes**	**No**
MRSA	**Yes**	**No**
HIV	**Yes**	**No**
Hepatitis	**Yes**	**No**

X_____ _____

Patient Signature D.O.B.

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Patient Name: _____ DOB: _____

Please Circle One

Do you have pain related to the condition in which you're being seen for today?

YES **NO**

Do you smoke?

YES **NO**

How many days a **YEAR** do you drink 5 or more (men) or 4 or more (women) alcoholic drinks in a day?

0 **1** **2** **3** **4+**

If you are 6 months of age or older, have you received the flu vaccine?

YES **NO**

If you are 65 years of age or older, do you have an advanced care plan or surrogate decision maker?

YES **NO**

If yes, please provide their name and phone #: _____

Do you have a living will?

YES **NO**

Please check one:

☐ Full Code
☐ Do Not Resuscitate
☐ Do Not Intubate