MAIN LINE DERMATOLOGY

PATIENT REGISTRATION

(ALL MINORS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY PARENT OR GUARDIAN ALL VISITS INCLUDING SUTURE REMOVAL)

NAME: _____ DATE OF BIRTH: _____ AGE: _____
(LAST, FIRST, MIDDLE INITIAL) (MALE/FEMALE) (MONTH ,DAY,YEAR)

ETHNICITY: Hispanic ___ Non-Hispanic___ **(required by insurance in compliance with health reform)**
RACE: American Indian or Alaskan Native ___ Asian ___ Black ___ Caucasian ___ Pacific Islander ___ Other___

STREET ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY PHONE: ( ) _____ CELL PHONE: ( ) _____

OCCUPATION/EMPLOYER: _____ OFFICE PHONE: _____

EMERGENCY CONTACT NAME/NUMBER: _____

EMAIL ADDRESS: _____ **ARE YOU INTERESTED IN BOTOX/FILLERS? Yes / No**

MARITAL STATUS: _____ SPOUSE'S NAME: _____ SPOUSE'S DOB: _____

PATIENT SOCIAL SECURITY NUMBER: _____ REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____ PHYSICIAN PHONE: _____

PRACTICE NAME AND ADDRESS: _____

_____

INSURED'S BILLING INFORMATION:

POLICY HOLDER NAME: _____ HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ RELATIONSHIP TO PATIENT: _____

CITY, STATE, ZIP CODE: _____ PHONE NUMBER: ( ) _____

PAYMENT REQUESTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE
HMO PATIENTS REQUIRE PROPER REFERRAL PRIOR TO TREATMENT

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Main Line Dermatology and its physicians to release any medical or incidental Information that may be necessary for either medical care or in processing application for financial benefits. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize direct payment of surgical/medical benefits to Main Line Dermatology, Inc. and its physicians for services rendered by them or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized Medicare and or insurer benefits be made on my behalf to Main Line Dermatology, Inc. for services furnished to me by said physicians. I understand that if under Medicare program guidelines, a necessary service is determined to be non-covered; I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the **Third Party Payer. PLEASE NOTE: ALL BIOPSIES ARE SENT TO AN OUTSIDE LAB TO BE PREPARED AND/OR INTERPRETED.** I acknowledge receipt of the "NOTICE OF PRIVACY PRACTICES" notice from this practice.

SIGNATURE: _____ **DATE:** _____

Dermatology Medical History

Patient: _____ Date: ___/___/_____

Reason for today's visit: _____

Are you allergic to any medications? ▫YES ▫NO If Yes, list below:
1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ▫YES ▫NO Any bad reaction? ▫YES ▫NO

List all medications you are currently taking (including prescriptions, over-the-counter, vitamins and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	▫	▫
Emphysema	▫	▫
Asthma	▫	▫
Chronic cough	▫	▫
Morning cough	▫	▫
Shortness of Breath	▫	▫
Wheezing	▫	▫

Cardiovascular:	YES	NO
High Blood Pressure	▫	▫
Chest Pain	▫	▫
Heart Attack	▫	▫
Heart Murmur	▫	▫
Irregular Heartbeat	▫	▫
Phlebitis	▫	▫
Inflammation of Vein	▫	▫
Blood Clots	▫	▫
Pacemaker	▫	▫

Other System:	YES	NO
Diabetes	▫	▫
Excessive thirst/hunger	▫	▫
Thyroid	▫	▫
Kidney	▫	▫
Bladder	▫	▫
Frequency/burning	▫	▫
Gastrointestinal	▫	▫
Stomach absorptive disorder	▫	▫
Nausea, vomiting, diarrhea when taking antibiotics	▫	▫
Yeast infection when taking antibiotics	▫	▫
Arthritis/ Joint Deformity	▫	▫
Arthralgia	▫	▫
Limited motion	▫	▫
Artificial joint	▫	▫
Convulsions, Epilepsy or Seizures	▫	▫
Fainting	▫	▫

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ▫YES ▫NO
Has anyone in your family had skin cancer? ▫YES ▫NO
Do you have a history of any specific skin diseases? ▫YES ▫NO If yes, _____
Do you have problems with healing? ▫YES ▫NO
Do you develop keloids (scars) after surgery? ▫YES ▫NO
Do you bleed easily? ▫YES ▫NO
Do you develop skin rashes in reaction to ▫Medication ▫Food ▫Environment? _____

Social History:

Do you drink alcohol? ▫YES ▫NO If YES: _____ drinks per day
Do you use IV drugs? ▫YES ▫NO If YES, what? _____ How often? _____
Do you smoke? ▫YES ▫NO If YES, how much? _____
Have you had or have been exposed to HIV (AIDS)? ▫YES ▫NO

Please answer the following questions:
(Women) Are you pregnant? ▫YES ▫NO Due Date: ___/___/_____
What is your occupation? _____ Hobbies? _____

Completed by: ▫ Patient
▫ Medical Assistant _____ Initials

_____ ___/___/___
Signed by Patient Date

_____ ___/___/___
Reviewed by Date

MAIN LINE DERMATOLOGY
AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name:_____

If you are under age 18, a parent or guardian must sign this form.

The physicians and/or staff of Main Line Dermatology may need to contact you in reference to an appointment, scheduled surgery, biopsy and/or lab results, or in order to schedule further treatment. In accordance with privacy laws we will not disclose patient Protected Health Information (PHI) to anyone other than the patient without written authorization (except where permitted per our Notice of Privacy Practices for Treatment, Payment and Health Care Operations).

The following statements authorize Main Line Dermatology to release medical information. Please enter your initials next to the statement authorized by you, and sign the bottom of this form. You may revoke these authorizations in writing at any time.

_____ I authorize Main Line Dermatology to leave a **detailed message** about my health care, test results and/or need for future treatment at the following telephone number.

Cell Number:
Home Number:
Work Number:

_____ I authorize Main Line Dermatology to leave a message for me to contact Main Line Dermatology. **No medical information will be left with this message.**

Cell Number:
Home Number:
Work Number:

_____ I am over 18 and authorize Main Line Dermatology to disclose any and all medical information to the following individuals.

Name(s) and relationship(s):

_____

Signature of Patient Date

Please note: If no option, or if both options one and two are checked, and this form is signed, we will call any telephone number we have on file for you.