Medicare Patient Registration

Name: _____ ☐Jr ☐Sr ☐Dr
First Middle Last

SS#: _____-_____-_____ **DOB:** _____/_____/_____ **Sex:** ☐ M ☐ F

Primary language: _____ **Race:** _____ ☐ Hispanic ☐ Non-Hispanic ☐ Decline

Preferred phone: ☐ Home ☐ Work ☐ Cell

Home #: (____) _____ Work #: (____) _____ Cell #: (____) _____

E-Mail address (used only for appointment confirmations): _____

Primary address: _____

_____
City State Zip Code

Secondary/Seasonal address: _____

_____
City State Zip Code

Start Date: _____ End Date: _____

Emergency Contact:
Name of Spouse/Close Relative or Friend: _____ Phone #: _____

Please answer questions below by placing a check in the appropriate column:

Yes	No	
☐	☐	Have you recently joined a Medicare HMO? If yes, identify: _____
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by an HMO/PPO which makes Medicare *secondary*?
☐	☐	Is this illness covered by the VA (Veteran's Administration)?
☐	☐	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness due to an automobile accident?
☐	☐	Is this illness due to an injury at work?
☐	☐	Are you receiving Medicaid?

- CONTINUED ON BACK -

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed the balance.

Insurance/Payment Information

Medicare Health Insurance Claim Number as it appears on your card. Be sure to include all letters & numbers.

_____

Please sign so we may have your Medicare Authorization on File: I authorize any holder of medical or other information about me to be released to the Social Security Administration, Health Care Financing Administration or its intermediaries or carrier of any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: ____/____/____ Signature: _____

Are you in a Medicare HMO or other Senior Medicare Advantage Plan? □ Yes □ No

Name of Plan: _____
Policy #: _____ Group #: _____
Name Policy Holder (Insured): _____ Sex: □ Male □ Female
DOB: ____/____/____

Supplemental (MEDIGAP) Insurance (This includes ALL SECONDARY insurances)

Please fill out below if you are covered by a supplemental plan which covers the 20% NOT covered by Medicare (MEDIGAP Coverage).

Name of Insurance Company: _____
Policy #: _____ Group #: _____
Name Policy Holder (Insured): _____ Sex: □ Male □ Female
DOB: ____/____/____

Please Sign So We May Have Your Supplemental Authorization on File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: ____/____/____ Signature: _____

Please present your MEDICARE AND SECONDARY INSURANCE CARD(S) and a photo ID to the receptionist along with this completed form. Thank you.

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 Practices.
- 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 receipt of treatment upon the execution of this Consent.

Acknowledgement of Notice of Privacy Practices

My signature below verifies that I, _____, have received
(Print Name)
a copy of the Notice of Privacy Practices from Romagosa Dermatology Group, LLC

Signature of Recipient _____ Date: _____/_____/_____

Protected Health Information Authorization

My signature below indicates that I □ **DO** / □ **DO NOT** (please check one) authorize Romagosa Dermatology Group, LLC to discuss my PHI with my spouse or personal representative.

If yes, please provide their name and phone number.
Name: _____ Phone #: _____-_____-_____
Relationship : _____

Signature of Patient _____ Date: _____/_____/_____

Romagosa Dermatology Group, LLC

Medical History and Intake Form

Patient Name: _____ **D.O.B.** _____

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

None

Past Surgical History: (please circle all that apply)

Appendix (Appendectomy)
Bladder: Cystectomy
Breast: Breast Biopsy
Breast: Lumpectomy (both)
Breast: Lumpectomy (left)
Breast: Lumpectomy (right)
Breast: Mastectomy: (both)
Breast: Mastectomy (left)
Breast: Mastectomy: (right)
Colon: Colon Cancer Resection
Colon: Diverticulitis
Colon: IBD
Colon: Colostomy
Gallbladder Removed
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant
Heart: Mechanical valve Replacement
Joint Replacement: Hip (both)
Joint Replacement: Hip (left)
Joint Replacement: Hip (right)
Joint Replacement: Knee (both)
Joint Replacement: Knee (left)
Joint Replacement: Knee (right)
Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney transplant
Kidney: Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Liver Shunt
Ovaries: Endometriosis
Ovaries: Ovarian Cancer
Ovaries: Tubal Ligation
Pancrease: Pancreatectomy
Prostate: Prostate Biopsy
Prostate: Prostate Cancer
Prostate: TURP
Rectum: APR
Spleen: Splenectomy
Testicles: Orchiectomy
Uterus: Hysterectomy (fibroids)
Uterus: Hysterectomy (Uterine Cancer)
Uterus: Hysterectomy(Cervical Cancer)

None

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

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Do you wear sunscreen? Yes No
If yes, what SPF? _____

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

Medications: (Please list all **CURRENT** medications)

_____
_____
_____

Allergies: (MEDICATION ALLERGIES ONLY)

_____
_____
_____

Social History: (Please circle)

Currently Smokes Never Smoked Former Smoker

Preferred Language: _____

Race: _____ **Ethnic Group:** _____

Preferred pharmacy Name: _____ **Pharmacy Phone #:** _____

Pharmacy City or Zip code: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement within 2 years
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Pregnant or currently trying to get pregnant
Hepatitis
Latex