MINOR PATIENT REGISTRATION FORM

Child's Name: _____ SS#: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Sex: □ Male □ Female

Home Address: _____

_____
City State Zip Code

Should statements of your account be sent to the above address? □ Yes □ No

Parent or Legal Guardian Name:

_____

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

DOB: ____/____/____ SS#: _____/_____/_____

Email Address (used only for appointment confirmations):

_____

In order to establish optimal relations with our patients and avoid 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.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Romagosa Barron Dermatology to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to Romagosa Barron Dermatology when an assigned claim is filed.

_____ _____/_____/_____
Parent/Legal Guardian Signature Date

Name of Insurance policy owner: _____
DOB of policy owner: ____/____/____

Patient relationship to policy owner: □ Child □ Other: _____
Do we have your permission to?

Leave a message on your answering machine at home? □ Yes □ No
Leave a message at your place of employment? □ Yes □ No
Discuss your medical condition with another member of your household? □ Yes □ No

If yes, whom: _____ Relationship: _____

_____ _____/_____/_____

Parent/Legal Guardian Signature Date

TREATMENT TO MINORS

Many times, parents find themselves unable to accompany their children to their appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child. This would also apply if your child is of driving age and has arrived to their appointment alone.

I hereby grant to Romagosa Barron Dermatology permission to treat my child, _____, for any dermatologic condition or procedure when they arrive at the office unaccompanied.

Signature of Parent: _____ Date: _____/_____/_____

CREDIT CARD AUTHORIZATION

Please fill out the following section if your child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied. I authorize the above provider to charge my credit card (listed below) under the circumstance that I am not present.

(Initials) _____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments and balances after primary insurance has paid, should my primary insurance be with a company with which the provider(s) are contracted.

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card #: _____ Expiration Date: _____/_____

Name as it appears on the credit card: _____

Signature: _____ 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

Continued on Back

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

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: _____/_____/_____