Patient Registration Form

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

SS#: _________-________-_________ DOB: ______/______/______ Sex: ☐ M ☐ F

Primary Language: ____________________ Race: ______________ ☐ Hispanic ☐ Non-Hispanic ☐ Decline

E-Mail address: ____________________________
Is it okay to email you about upcoming cosmetic promotions and events (your e-mail will not be shared with any outside parties)? **Yes** or **No**

Primary address: ____

____
City State Zip Code

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

Secondary address: ____

____
City State Zip Code
Home #: (____) ______________

Insurance Information: Do you have health insurance? ☐ Yes ☐ No (if yes, please complete below)

Primary Insurance Carrier: ______________________________ Policy type: ☐ PPO ☐ HMO
Address: ____
Name of Insured (Guarantor): ____________________ Guarantor Date of Birth: _____/_____/_____
SS#: ________-________-________ Policy #: ______________________________
Relationship to Insured: ______________________________

Secondary Insurance Carrier: ______________________________ Policy type: ☐ PPO ☐ HMO
Address: ____
Name of Insured (Guarantor): ____________________ Guarantor Date of Birth: _____/_____/_____
SS#: ________-________-________ Policy #: ______________________________
Relationship to Insured: ______________________________

Emergency Contact (In Case of Emergency)

Name of Spouse/Close Relative or Friend: ______________________________
Home #: (____) ____________________ Cell #: (____) ____________________

Name of Spouse/Close Relative or Friend: ______________________________
Home #: (____) ____________________ Cell #: (____) ____________________

Please present your insurance card(s) and your photo ID to the receptionist along with this completed form. The receptionist will make a copy and return them to you promptly. Thank You.

- OVER -

PLEASE READ AND SIGN

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient signature: ______________________________ Date: _____/_____/_____

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 for all services at the time they are rendered unless you are in a pre-paid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient signature: ______________________________ Date: _____/_____/_____

Romagosa Dermatology Group, LLC
Medical History and Intake Form

Patient Name: ____**Date of Birth:**_________________

Past Medical History: (please circle all that apply)

Anxiety	Depression	
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
Bone Marrow Transplantation	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Treatment
Colon Cancer	High Blood pressure	Seizures
COPD	HIV/AIDS	Stroke
Coronary Artery Disease	High Cholesterol	
	Thyroid Problems	NONE

Other :____

Past Surgical History: (please circle all that apply)

Appendix Removed	
Bladder Removed	Joint Replacement within last 2 years
Mastectomy (Right, Left, Bilateral)	Kidney Biopsy (Nephrectomy)
Lumpectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Breast Biopsy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Reduction	Kidney Transplant
Breast Implants	Ovaries Removed: Endometriosis
Colectomy: Colon Cancer Resection	Ovaries Removed: Cyst
Colectomy: Diverticulitis	Ovaries Removed: Ovarian Cancer
Colectomy: IBD	Prostate Removed: Prostate Cancer
Gallbladder Removed	Prostate Biopsy
Coronary Artery Bypass	TURP (Prostate Removal)
Mechanical Valve Replacement	Spleen Removed
Biological Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Heart Transplant	Hysterectomy: Fibroids
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement, Hip (Right, Left, Bilateral)	

NONE

Other:____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other:____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Romagosa Dermatology Group, LLC
Medical History and Intake Form

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)

____

____

____

Allergies: (Please enter all allergies)

____

____

____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other:____

Family History (Only first degree relatives)

____

____

____

____

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
Blood thinners

Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Pregnant or currently trying to get pregnant?

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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: _______/_______/_______

To Our Patients:

As you know if you have ever checked into a hotel or rental car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At the time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Romagosa Dermatology Group, LLC

I authorize Romagosa Dermatology Group, LLC to charge outstanding balances on my account to the following credit card:

Visa MasterCard American Express Discover Other: ________________________

Account number: _______________________________________ Expiration Date: _________________

Name on card (please print):____

Signature: ____ Date: __________________

optional