

Memorial Dermatology Medical History



Name _____ Date _____

Reason for today's visit: _____

Do you have any specific skin diseases? _____

Please list all medications (including over-the-counter & herbals): _____

Are you allergic to any medications? Yes No Please list _____

What is your occupation? _____ Hobbies? _____

Do you have now, or have you ever had diseases or conditions of:

	Yes	No		Yes	No
Lungs			Other Systemic		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequent bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections on antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint deformity	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Limited joint motion	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of veins	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			

List any other diseases or conditions: _____

List surgical procedures you have had in the last year: _____

Skin:

	Yes	No	
Have you ever had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Location & date _____
Has anyone in your family had melanoma?	<input type="checkbox"/>	<input type="checkbox"/>	Who? _____
Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you develop keloids (bad scars) after surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you develop skin rashes in reaction to:	<input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Environment? _____		

Social History:

	Yes	No	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, _____ drinks per day
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much: _____
Do you wear sunscreen daily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have or have you been exposed to HIV (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	

Women:

Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Due Date _____
Are menstrual cycles regular?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last cycle _____

Signature _____

Memorial Dermatology Patient Registration Form



Date _____

Name _____ Age _____ Date of Birth _____

Address _____ City/State _____ Zip _____

Home Phone _____ Daytime / Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Work Address _____ City/State _____ Zip _____

Social Security # _____ Sex: M / F Marital Status S / M / D / W

Primary Care Physician _____ Office Phone _____

Who referred you to our office? _____

Do we have permission to: Leave a message on your answering machine at home? _____ at work? _____

Discuss your medical condition with any member of your household? _____ If yes, whom: _____

Please enter information on the person responsible for the bill if other than the patient.

Name _____ Relationship _____ Date of Birth _____

Address _____ City/State _____ Zip _____

Daytime Phone _____ Evening Phone _____ Social Security # _____

Emergency Contact (Nearest relative or friend)

Name _____ Relationship _____ Daytime Phone _____

Insurance Information

Primary Carrier _____

Secondary Carrier _____

Insured Name _____

Insured Name _____

Insured Date of Birth _____

Insured Date of Birth _____

Insured Employer _____

Insured Employer _____

ID# _____

ID# _____

Group # _____

Group # _____

Your relationship to insured _____

Your relationship to insured _____

Patient (or Guardian Signature) _____ Date _____



Guarantor Agreement / Acknowledgement of Notice of Privacy Practices

I authorize Memorial Dermatology to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Memorial Dermatology. I understand that Memorial Dermatology will file my insurance claim as a courtesy to me, and as such, is not required to wait for extended delays in payment. I understand that I am fully responsible for any non-covered services, denied services, health insurance deductibles, or unassigned portion of charges at this office.

I understand that Memorial Dermatology does NOT file to secondary insurance and I must file the claim if it does not crossover automatically from Medicare. (If your secondary insurance is an automatic crossover, Medicare will send the claim automatically to them. If not, the patient is responsible for the deductible and 20% copay at the time service is rendered. The patient will need to send the Medicare explanation of benefits to the secondary carrier.)

I have received a copy of the Notice of Privacy Practices for Memorial Dermatology. I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice. I know that if I do not consent, services cannot be provided to me.

I have read and understand all of the following:

- 1) Payment (in the form of cash, check or credit card [Visa, Mastercard]) is required for all services and/or copayments at the time of visit.
- 2) Returned checks will be charged a \$25 fee to cover processing and bank fees.
- 3) Overdue accounts (more than 30 days past due) are subject to a 1 ½ % monthly late charge fee. In the event that a delinquent account must be turned over to collections, the patient is responsible for all attorney fees, court costs and collection agency fees associated with the collection process.
- 4) In order to provide the best possible service and availability to all our patients, it is office policy to charge a \$30 fee for any appointments not cancelled at least 24 hours prior. This fee is NOT covered by insurance and is the full responsibility of the patient. Please call us as early as possible if you know you will need to reschedule your appointment.
- 5) **HMO (Managed care) patients:** It is the responsibility of HMO patients to ensure that they have obtained a referral for all appointments with this office, if needed. The patient is financially responsible for any and all services rendered that are not a part of the referral, if not covered or paid by insurance. If you did not get a referral for a specialist office visit, your insurance company will require you to pay the full amount for all services.
- 6) **PPO patients:** Most insurance companies consider all dermatology procedures (such as skin biopsies or freezing off warts) to be surgical in nature. They will often apply these costs to your deductible. When we verify insurance for your appointment, we are given a general idea about your coverage, but we will not know exactly what they cover until we send off the claim and receive an explanation of benefits (EOB). It is a good idea for you to become well acquainted with the specifics of your coverage. If you want to delay a particular procedure until you know these details, the front desk staff will be happy to provide you with the appropriate medical codes for you to give to your insurance company.
- 7) **Parents of young children:** While we strive to provide a safe environment for everyone, medical exam rooms can be a dangerous place for unsupervised children. Please watch your children closely. For their safety, it is extremely important to keep them away from the medical waste trash can, the drawers and cabinets, and the Doctor's rolling stool. At your request, we can remove some of these items from the room for you.

Patient (or Guardian) Signature _____ Date _____



Memorial Dermatology No-Show and Same Day Cancellation Policy

Memorial Dermatology is committed to scheduling each patient with enough time to allow for the attention necessary to give the best care possible.

Because we do not over-book, no-shows and same-day cancellations can pose a significant hardship on our practice.

Additionally, appointment slots that are booked and then result in no-shows or same-day cancellations contribute to the length of time it takes for all patients to schedule an appointment.

The fee for no-shows and same-day cancellations is \$30, as noted in our Acknowledgment of Privacy Practices Notice.

We hope you understand, and respect the value of our time as we respect yours.