**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:

| **Lungs** | **Yes** | **No** |
|---|---|---|
| Bronchitis | [ ] | [ ] |
| Emphysema | [ ] | [ ] |
| Asthma | [ ] | [ ] |
| Chronic cough | [ ] | [ ] |
| Shortness of breath | [ ] | [ ] |
| Wheezing | [ ] | [ ] |
| **Cardiovascular** | | |
| High blood pressure | [ ] | [ ] |
| Chest pain | [ ] | [ ] |
| Heart attack | [ ] | [ ] |
| Heart murmur | [ ] | [ ] |
| Irregular heartbeat | [ ] | [ ] |
| Inflammation of veins | [ ] | [ ] |
| Blood clots | [ ] | [ ] |
| Pacemaker | [ ] | [ ] |

| **Other Systemic** | **Yes** | **No** |
|---|---|---|
| Diabetes | [ ] | [ ] |
| Excessive thirst/hunger | [ ] | [ ] |
| Thyroid problems | [ ] | [ ] |
| Kidney problems | [ ] | [ ] |
| Frequent bladder infections | [ ] | [ ] |
| Yeast infections on antibiotics | [ ] | [ ] |
| Fainting | [ ] | [ ] |
| Convulsions or seizures | [ ] | [ ] |
| Arthritis/joint deformity | [ ] | [ ] |
| Limited joint motion | [ ] | [ ] |
| Artificial joint | [ ] | [ ] |
| **Gastrointestinal** | | |
| Stomach absorptive disorder | [ ] | [ ] |
| Nausea, vomiting, diarrhea | [ ] | [ ] |
| when taking antibiotics | [ ] | [ ] |

List any other diseases or conditions _____

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

| **Skin:** | **Yes** | **No** | |
|---|---|---|---|
| Have you ever had skin cancer? | [ ] | [ ] | Location & Date _____ |
| Has anyone in your family had melanoma? | [ ] | [ ] | Who? _____ |
| Do you have problems with healing? | [ ] | [ ] | |
| Do you develop keloids (bad scars) after procedures? | [ ] | [ ] | |
| Do you bleed easily? | [ ] | [ ] | |

Do you develop skin rashes in reaction to: [ ] Medications [ ] Food [ ] Environment? _____

| **Social History:** | **Yes** | **No** | |
|---|---|---|---|
| Do you drink alcohol? | [ ] | [ ] | If yes, _____ drinks per [ ] day [ ] week [ ] month |
| Do you use tobacco products? | [ ] | [ ] | If yes, how much _____ |
| Do you wear sunscreen daily? | [ ] | [ ] | |
| Do you have or have you been exposed to HIV (AIDS)? | [ ] | [ ] | |
| Flu vaccine received? | [ ] | [ ] | Date received _____ |
| Pneumonia vaccine received? | [ ] | [ ] | Date received _____ |
| **Women:** | | | |
| Are you pregnant? | [ ] | [ ] | Due Date_____ |
| Are your menstrual cycles regular? | [ ] | [ ] | Date of last cycle_____ |

Patient (or Guardian) Signature _____ Date_____

Memorial Dermatology

**Patient Registration Form**

Date_____

Name_____ Age_____ Date of Birth _____

Address _____Apt#_____ City/State_____ Zip_____

1st Phone# _____ [ ] Cell [ ] Home [ ] Work 2nd Phone# _____ [ ] Cell [ ] Home [ ] Work

3rd Phone# _____ [ ] Cell [ ] Home [ ] Work Email_____

Employer_____ Occupation_____

Work Address _____ City/State _____ Zip _____

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

Primary Care Physician _____ Phone# _____

Who referred you to our office? _____

Do we have permission to: Leave a message on [ ] Cell [ ] Home [ ] Work [ ] Email

Discuss your medical condition with someone? _____ If yes, whom: _____

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

Name_____ Relationship _____ Date of Birth_____

Address_____ Apt#_____ City/State_____ Zip_____

1st Phone#_____ 2nd Phone# _____ Social Security # _____

Emergency Contact (nearest relative or friend)

Name_____ Relationship_____ Phone#_____

*Insurance Information*

Primary Insurance_____

Policy Holder_____

Policy Holder Date of Birth_____

Policy Holder Employer_____

ID#_____

Group#_____

Relationship to Policy Holder_____

Secondary Insurance_____

Policy Holder _____

Policy Holder Date of Birth _____

Policy Holder Employer _____

ID#_____

Group#_____

Relationship to Policy Holder_____

Patient (or Guardian) Signature _____ Date_____

## Guarantor Agreement / Acknowledgment of Notice of Privacy Practices / Laboratory Authorization

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

I understand that Memorial Dermatology / Greg William Pearson, M.D. does NOT file secondary insurance claims and I must file the claim if it does not crossover automatically. 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% coinsurance at the time of service is rendered. The patient will need to send the Medicare explanation of benefits to the secondary carrier.

I have received (upon request) a copy of the Notice of Privacy Practices for Memorial Dermatology / Greg William Pearson, M.D. I consent to the use and sharing of my health records for treatment. Payment and operation purposes as described in the notice. I know if I do not consent, services cannot be provided to me.

**Laboratory Authorization:** Skin, nail and hair samples are routinely sent to a laboratory for microscopic evaluation to determine or confirm proper diagnosis. This will be a separate charge from our office charges. I authorize and understand that I am responsible for the cost of any testing or lab services performed for me and that billing of such services may be billed independently by another physician or laboratory. I further understand that any balance not paid after 90 days, regardless of insurance coverage, may be referred to a collection agency.

I have read and understand all of the following:

1. Payment ***(cash, check, Visa, Master Card, and Discover)*** is required for all services and/or copayments, deductibles, coinsurance.
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 1½% 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 our 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 payment.
5. **HMO / Managed Care patients:** It is the responsibility of the patient 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, your insurance company will require you to pay the full amount for all services.
6. ***Most insurance companies consider all dermatology procedures (such as skin biopsies or freezings) to be surgical in nature. They will often apply these costs to your deductible/coinsurance. The patient responsibility is due at the time services are rendered.*** When we verify insurance, we are given a good 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. 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 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 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, cabinets and the Doctor's rolling stool. At your request, we can remove some of these items from the room for you.

My signature below signifies my understanding and willingness to comply with this policy.

Consenting Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____