DERMATOLOGY
MEDICAL ASSOCIATES

PATIENT REGISTRATION FORM

Name: ______________________________
Nickname: ______________________________
Date of Birth: ____________________ *( ) Male ( ) Female*
Social Security: ______________________________
Mailing Address: ______________________________
City: ______________________________
State: ____________ *Zip Code:* ____________
Home Phone: ______________________________
Cell Phone: ______________________________
Work Phone: ____________ *Marital Status:* ____________

Referring Physician: ______________________________
Emergency Contact: ______________________________
Emergency Phone: ______________________________
Emergency Relationship: ______________________________
Patient's Employer: ______________________________
Employer's Address: ______________________________
City: ______________________________
State: ____________ Zip Code: ____________
Occupation: ______________________________

RESPONSIBLE PARTY: Person responsible for payment. (If patient is a minor).

Name: ______________________________
Nickname: ______________________________
Date of Birth: ______________________________
Social Security: ______________________________
Mailing Address: ______________________________
City: ______________________________
State: ____________ Zip Code: ____________

Home Phone (if different): ______________________________
Date of Birth: ______________________________
Social Security: ______________________________
Employer of Responsible Party: ______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize Dermatology Medical Associates to release my information necessary for my course of treatment to: ("X" indicates information that may be shared with those specified.)

( ) My spouse: ______________________________
( ) My significant other: ______________________________
( ) Other: ______________________________
( ) Leaver a message on my answering Machine?
YES / NO

( ) Any/All information to be shared Initial: ______
( ) Appointment time/date Initial: ______
( ) Medication(s) Initial: ______
( ) Radiation/Laboratory results Initial: ______
( ) Procedure/Surgery information Initial: ______

MEDICAL CONSENT: I consent to the examination, treatment, and procedures which may be performed during the office visit, including emergency treatment considered necessary by the physician. If an invasive procedure is necessary, a specific consent form will be discussed with me at that time.

FINANCIAL POLICY AND CONSENT: Payment of deductibles and co-payments is expected at the time of service. I understand that I am responsible for the balance owed to Dermatology Medical Associates after my insurance carrier(s) have been billed. I agree to pay for services rendered to me without regard to any benefit limitations imposed by any insurance carrier, unless prohibited by law or contract. I consent to Dermatology Medical Associates use and disclosure of my health information to any person or organization that is legally or contractually responsible for payment of my bill for the service I received. I also consent to Dermatology Medical Associates' disclosure of my health information to attending and consulting providers for billing purposes.

Patient Signature: ______________________________ Date: ____________

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PATIENT HISTORY

Patient Name:____Date__________________

Nature of Problem____

Past History:

1. Major Illness:____

2. Major Operations ____
____

3. Do you have:
Diabetes?________Heart Disease?__________High Blood Pressure?______________
Pacemaker?__________Artificial Joints?_____________Arthritis?______________

4. ALLERGIES to Medication, Latex, Food or Environmental surroundings________________
____

5. Have you ever been treated for SKIN CANCER?__________________________________
What type?________________________

6. Is there an immediate family History of Skin Cancer?______________If yes, explain
____

7. DO YOU SMOKE?________________

8. HAVE YOU EVER HAD A PNEUMONIA VACCINE?_________________

9. MEDICATIONS YOU ARE CURRENTLY TAKING (Example – Allegra 180 mg. daily)

____

____

____

10, If Patient is Female, Are you Pregnant?________If so, how many weeks?___________

11. Which PHARMACY do you use?____

12. Who is your Primary Doctor? ____

How did you hear about us? (Example: Website, Family, Friend, Driving by)____________________

SIGNATURE____DATE______________

DERMATOLOGY
MEDICAL ASSOCIATES

FORM OF WRITTEN ACKNOWLEDGEMENT OF RECEIPT

OF DERMATOLOGY MEDICAL ASSOCIATES

NOTICE OF PATIENT PRIVACY PRACTICES

BY SIGNING THIS WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF:
DERMATOLOGY MEDICAL ASSOCIATES NOTICE OF PATIENT PRIVACY PRACTICES (ACKNOWLEDGEMENT"), I HEREBY EXPRESSLEY ACKNOWLEDGE MY RECEIPT OF DERMATOLOGY MEDICAL ASSOCIATES OF PRIVACY PRACTICES.

____

PATIENT, OR LEGAL REPRESENTATIVE, SIGNATURE

____

PRINTED NAME OF PATIENT, OR LEGAL REPRESENTATIVE DATE

ACKNOWLEDGEMENT NOT OBTAINED BECAUSE;

_______PATIENT OR LEGAL REPRESENTATIVE, DECLINED NOTICE OF PATENT PRIVACY PRACTICES

_______OTHER, BRIEFLY DESCRIBE

____

Timothy Highley, DO • Jeremy Davidson, PA-C • Teresa Davidson, PA-C

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