LOWCOUNTRY DERMATOLOGY ASSOCIATES

NEW PATIENT REGISTRATION

Last Name, First Name _____ Middle Initial____ Nickname_____

SSN#: _____ Date of Birth: _____ Age: ____ Sex: M / F Marital Status: S M D W

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method: Cell phone_____ Home Phone _____ Work Phone _____

Email Address: _____

Military: Y / N If yes, are you Retired? ☐ Yes ☐ No Race: _____ Ethnicity:_____

Employer: _____ Occupation: _____

Guardian /Parent Name (if patient is under 18):_____

Guardian/Parent SSN#: _____ Guardian/Parent Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Emergency Contact: _____ Phone Number: _____

Do you have a Primary Care Physician? ☐ Yes ☐ No
If so, who? _____ Phone Number: _____

Were you referred by a Physician to our practice? ☐ Yes ☐ No
If so, who? _____ Phone Number: _____

Primary Insurance: _____ Policy Holder's Name: _____

Policy Holder's SSN# (required): _____ Policy Holder's DOB (required):_____

Secondary Insurance: _____ Policy Holder's Name: _____

Policy Holder's SSN# (required): _____ Policy Holder's DOB (required): _____

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST

I hereby authorize the physician to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original. I also give consent for my photo to be taken and used as part of my plan of treatment and confidential medical record.

Signature of Patient or Parent/Guardian: _____ Date: _____

Lowcountry Dermatology Associates: Medical History

Patient: _____ Date of Birth: ____/____/____ Chart#: _____

Do you have now or have you ever had any of the following past medical history?

	Y	N		Y	N		Y	N
Abnormal Bleeding	☐	☐	Heart Murmur	☐	☐	Seizures/Fainting/Epilepsy	☐	☐
Alcohol/Drug Dependency	☐	☐	Hepatitis B or C-	☐	☐	Please specify_____		
Anxiety/History of Anxiety	☐	☐	Please Specify_____			Inflammatory Bowel Disease/		
Arthritis/Joint Pain	☐	☐	High Blood Pressure	☐	☐	IBS/GERD	☐	☐
Asthma	☐	☐	High Cholesterol	☐	☐	Please specify_____		
Cancer (what type) _____			HIV/AIDS	☐	☐	Stroke	☐	☐
Defibrillator	☐	☐	Kidney Disease	☐	☐	Thyroid Disorder	☐	☐
Depression	☐	☐	Liver Disease	☐	☐	Tuberculosis/History of TB	☐	☐
Diabetes	☐	☐	Lupus/SLE	☐	☐	Joint Replacement	☐	☐
Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Please Specify_____		
Hay Fever/Allergies	☐	☐	Multiple Sclerosis	☐	☐			
Heart Attack/Heart Disease	☐	☐	Pacemaker	☐	☐			

Please list any other medical conditions not listed above: _____

_____

Do you have now or have you ever had any of the following past medical skin history?

	Y	N		Y	N
Acne	☐	☐	Actinic Keratosis (precancer)	☐	☐
Eczema	☐	☐	Atypical/Dysplastic Moles	☐	☐
Fever Blisters/Cold Sores/Herpes Simplex	☐	☐	Melanoma	☐	☐
Keloid(s)/Scars/Healing Problems	☐	☐	Basal Cell Carcinoma	☐	☐
Skin Allergies/Sensitive Skin	☐	☐	Squamous Cell Carcinoma	☐	☐
Psoriasis	☐	☐	Proven Skin Cancer-Unknown Type	☐	☐
Rosacea	☐	☐			

Do you have a family history of the following?

	Y	N		Y	N		Y	N
Acne	☐	☐	Endocrine Disease	☐	☐	Psoriasis	☐	☐
Abnormal Bleeding/Hemophilia	☐	☐	Heart Disease	☐	☐	Skin Disease	☐	☐
Autoimmune Disorders	☐	☐	High Blood Pressure	☐	☐	**Please Specify** _____		
Cancer	☐	☐	Hemophilia	☐	☐	Skin Cancer- Melanoma	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐	Skin Cancer- Basal Cell	☐	☐
Eczema	☐	☐	Liver Disease	☐	☐	Skin Cancer- Squamous Cell	☐	☐
						Skin Cancer-Type Unknown	☐	☐

Please List all previous surgeries:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Are you allergic to any medications? □ y □ n **If yes, list below:**

1._____2._____3._____

List all current medications (ie: prescriptions, acne medications, OTC medications, and vitamins):

1._____2._____3._____

4._____5._____6._____

Are you allergic to any of the following?

Local Anesthetic (lidocaine) □ y □ n Latex □ y □ n Adhesive Tape □ y □ n

Have you received your Flu Vaccine? □ y □ n Pneumonia Vaccine □ y □ n

Do you drink alcohol? □y □n

Do you smoke? □y □n # of packs per day: _____ Do you use chewing tobacco? □ y □ n

Do you use illegal drugs? □y □n

FEMALE PATIENTS ONLY

Are you pregnant? □ y □ n

Are you nursing? □ y □ n

Are you trying to become pregnant? □ y □ n

Type of Contraception (please choose at least one option):

None	□	IUD	□
Actively trying to conceive	□	Oral Contraceptive (birth control pills)-	□
Abstinence (not sexually active)	□	**Please specify pill name**_____	
Condoms	□	Post-Menopausal	□
Hormone Implant	□	Tubal Ligation	□
Hormone Shot (Depo or Other)	□	Vaginal Ring (NuvaRing)	□
Partner Vasectomy	□	Other- Please Specify _____	
Hysterectomy	□		

Patient/Guardian Signature: _____ **Date** ___/___/___

Pharmacy Name: _____ **Phone:** _____

Patient Name: _____ Date: _____

What is your reason for your visit today? _____

_____

How did you hear about us?

☐ My physician	Full Name:
☐ My insurance company provider	Name:
☐ The yellow pages	
☐ A friend or family member	Name:
☐ Internet	Website:
☐ Seminar	Date/Location:

☐ Approval to contact you	Best phone number to reach you:
☐ Approval to send you information on products and services(including special offers)	Email address:

Photo Consent

I give consent for medical photographs to be made of me or my child (or for person whom I am legal guardian). I understand that the photos will become a part of my medical record and will be used for medical record purposes only. _____Yes _____No

Patient/ Guardian Signature _____ **Date** _____

Financial Policy

Lowcountry Dermatology Associates is dedicated to you and your well-being. We promise to do our best to provide you with the highest possible care available. As a private practice, we are not subsidized by any government or private programs. We offer our service to you at a competitive price that is comparable to any other Dermatology practice in the area

Medical patients fall into 1 of 2 financial categories:

1. An insurance company provides payment through a healthcare policy purchased by an employer for an employee, or purchased by an individual. (Insured)
2. A patient pays the physician directly for healthcare services. (Self-Pay)

Insured Patients

Insurance coverage will normally cover payment for some of the healthcare services we provide. Most insurance plans have co-pays, deductibles, or co-insurances that are paid by the patient.

For the plans that Lowcountry Dermatology Associates participates with, we will honor the amount allowed by your insurance company. We will file your claim with them for reimbursement of the charges associated with the services we provided, and we will write off the amount we have agreed to discount. If your plan has a copay/deductible/co-insurance, we are required by the agreement, to collect it at the time of service. We cannot pre-determine what your insurance carrier will/will not define as necessary care. We believe that should be determined by your physician. If, for whatever reason, the company does not pay for the services, please understand you will be responsible for the unpaid balance. You will receive a detailed statement including your insurance companies' response. Due to the delay in receiving payment for the services, and the cost of communicating with them and you, we would appreciate your timely response to any balance remaining. For your convenience, we accept Visa, Mastercard, cash, or check.

Self Pay Patients

For patients that are presently without insurance coverage, we want you to know that both your physical and financial interests are considered as we treat your illness, however, we are primarily dedicated to treating that illness as effectively as we can. For us to remain efficient and viable, we ask that you pay for treatment at the time of service. Unfortunately, it is impossible to determine what the cost of the care will be prior to the date of service. We will do our best to inform you of what to expect along the way, but please understand that we do not have control over the cost of many of the elements involved in that care.

You agree, in order for us to service your account or to collect **any** amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We are contracted with an outside collection agency to help collect outstanding, past due balances. You also authorize and consent to us providing your contact information to any third-party for the express purpose of collecting any amounts you may owe. If you have a returned check, you will be charged a $30.00 billing fee. We are devoted to your care and well-being. Thank you for your cooperation and understanding of our financial policy.

Patient/ Guardian Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS
ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Lowcountry Dermatology Associates. I authorize Lowcountry Dermatology Associates to provide to my insurance company any information necessary to process claims for services rendered to me.

_____ _____

Signature of Patient/Guardian **Date**

MEDICARE

I authorize medical or other information about me to be released to the Social Security Administrations and Health Care Financing Administration or its intermediaries or carrier needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Are you covered by any other insurance that makes Medicare secondary? Y / N

If Medicare is your secondary insurance, please circle the type of coverage you have:

1. Working Aged/Spouse Group Plan
2. ESRD
3. No Fault/Auto Primary
4. Worker's Comp
5. Public Health Service/ Other Fed Agency
6. Veteran's Admin
7. Disabled
8. Beneficiary Under age 65
9. Other Liability Ins is Primary
10. Black Lung

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? YES _____ NO _____

_____ _____

Signature of Patient/Guardian **Date**

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which you're Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of Patient/Guardian **Date**

Lowcountry Dermatology Wants You to Know How We Protect Your Private Health Information

Please review the Notice of Health Information Privacy Practices of Lowcountry Dermatology. If you have any questions or concerns, please do not hesitate to ask one of our staff members.

I acknowledge that I have read the practice's Notice of Privacy Practices and have been given an opportunity to ask questions. (A copy of the practice's Notice of Privacy Practices is available upon request)

Patient Name: _____

Signature of Patient or Personal Representative: _____ **Relationship to Patient:** _____ **Date:** _____

Consent to Disclose Information to Family Member and/or Personal Representative

You may give Lowcountry Dermatology written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or another party that you designate.

At my request, I authorize Lowcountry Dermatology to disclose my protected health information to:
if name is not listed, we *CANNOT* disclose any of your information to anyone other than yourself

1. Family Member/Personal Representative: _____
   Relationship to Patient: _____ Phone Number: _____

2. Family Member/Personal Representative: _____
   Relationship to Patient: _____ Phone Number: _____

At my request, I also authorize Lowcountry Dermatology to communicate my protected health information to me via the following methods:

- ☐ Leave detailed message on my home answering machine (phone #: _____)
- ☐ Leave detailed message on my voice mail at work (phone #: _____)
- ☐ Leave detailed message on my cell phone voice mail (phone #: _____)
- ☐ Fax detailed medical information (fax #: _____)

I understand that I may cancel this authorization at any time by notifying the practice in writing. I also understand that the cancellation will not affect any action Lowcountry Dermatology took in reliance on this authorization before written notice of cancellation.

Authorized Signature: _____ **Date:** _____