Copay $ _____

New Patient Registration Form

General Information (please print)

Name:_____ DOB:_____ Sex: ☐M ☐F

Social Sec #:_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Primary Address:_____

City: _____ State: _____ Zip:_____

Phones: Home (____) _____ Work (____) _____ Cell (____) _____

Emergency Contact:_____ Relationship:_____ Phone: (____) _____

E-mail:_____ Authorize E-mail? ☐Yes ☐No

Pharmacy Name:_____ Street:_____ City:_____

Employment Status: ☐Employed ☐Not Employed ☐Retired ☐Student

Employer:_____ Occupation:_____

Doctor Information

Referring Physician:_____ Specialty:_____

Primary Care Physician:_____ Phone: (____) _____

Primary Insurance

Insurance Name:_____ Insurance#:_____

Subscriber's Name:_____ DOB: _____ Relationship to Insured:_____

Secondary Insurance

Insurance Name:_____ Insurance#:_____

Subscriber's Name:_____ DOB: _____ Relationship to Insured:_____

CONSENT: PATIENT PHONE MESSAGES

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you give consent for us to:

- Leave a detailed message on voice mail/machine (INITIAL yes or no) _____YES _____NO
- Leave a detailed message with individual answering the phone (INITIAL yes or no) _____YES _____NO

CONSENT: SHARING OF MEDICAL INFORMATION

I give the physician and office staff of FOLSOM DERMATOLOGY, INC. consent to discuss my medical condition with the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Initials:_____ Date:_____

New Patient Registration Form

Patient Name:_____

CONSENT: MEDICAL PHOTOGRAPHY

I authorize my physician and FOLSOM DERMATOLOGY staff to photograph me for medically related documentation purposes only.

Patient Initials:_____ Date:_____

PATIENT AUTHORIZATION: ePRESCRIBE

ePrecribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of FOLSOM DERMATOLOGY to enroll me in the ePrescribe Program.

Patient Initials:_____ Date:_____

PATIENT AUTHORIZATION: PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of FOLSOM DERMATOLOGY to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payors for treatment purposes.

Patient Initials:_____ Date:_____

PATIENT AUTHORIZATION: MEDICARE PATIENTS only

I authorize the physician and/or staff of FOLSOM DERMATOLOGY to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any 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 to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services not covered by Medicare.

Patient Initials:_____ Date:_____

PATIENT AUTHORIZATION: PPO and HMO PATIENTS only

I authorize the physician and/or staff of FOLSOM DERMATOLOGY to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above-named insurance company to pay directly to Folsom Dermatology, Inc. the amount due for medical or surgical services. I understand that I am financially responsible for any services not covered by my insurance company.

Patient Initials:_____ Date:_____

PATIENT AUTHORIZATION: SPECIAL ACCOMODATIONS

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify FOLSOM DERMATOLOGY of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show for the scheduled appointment, all charges incurred by FOLSOM DERMATOLOGY are the patient's responsibility.

Patient Initials:_____ Date:_____

ACKNOWLEDGEMENT: RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge that you have read or received a copy of the notice. You may refuse to sign the acknowledgement, if you wish. *I acknowledge that I have received a copy of the FOLSOM*

DERMATOLOGY'S Notice of Privacy Practices.

Patient Initials:_____ Date:_____

New Patient Registration Form

Patient Name:_____

ACKNOWLEDGEMENT: MISSED APPOINTMENTS

In order to provide the best service to all of our patients, we require 24 hours advance notice if you are unable to keep your appointment. If a patient does not provide a minimum of 24 hours' notice to cancel the appointment or does not show for the scheduled appointment, a fee of $75.00 may be charged.

Patient Initials:_____ Date:_____

ACKNOWLEDGEMENT: FINANCIAL RESPONSIBILITIES

FOLSOM DERMATOLOGY appreciates the confidence you have shown in choosing us to provide for your health care needs. The services provided by our office are to be paid in full and imply a financial responsibility on your part and on your insurance carrier. As a courtesy, our office will bill your primary and secondary insurances carriers on your behalf but does not accept responsibility for collecting your claim or for negotiating a disputed claim.

Your insurance is a contract between you and your insurance carrier, not with the provider.

PATIENT FINANCIAL RESPONSIBILITIES

- **PRIOR TO YOUR VISIT: Obtain an Explanation of Benefits (EOB) from your insurance carrier and know your responsibilities for co-payments, deductibles, co-insurance, and both covered and non-covered services.**
- **PRIOR TO YOUR VISIT: If your insurance carrier requires prior authorization for a Dermatology visit and/or a referral from your primary care physician, please secure the necessary documents well in advance of your scheduled appointment. Failure to do so may result in your appointment being cancelled or rescheduled or you being responsible for full payment of all charges.**
- **IDENTIFICATION: Provide proof of insurance and picture identification at each visit. This is for your protection against insurance fraud.**
- **REGISTRATION: Provide any co-payments required by your insurance carrier at the time of registration. If you are a self-paying patient or are covered under insurance for which we are not plan participants, payment is due at the time of registration.**
- **BEFORE YOU LEAVE: Pay any additional fees generated during the visit prior to leaving the office, including but not limited to services not covered by your insurance carrier, services unrelated to the current visit, product purchases, etc.**
- **ADDITIONAL SERVICES: If specimens are obtained at your visit, they will be sent to a contracted diagnostic service (laboratory or pathology) outside our office. These services are completely separate entities. You will be responsible for any insurance claims and payments with them directly and not through FOLSOM DERMATOLOGY.**
- **BILLING: Once your insurance carrier has responded to our claim, you will be billed for the balance and expected to pay upon receipt of your statement. Accounts over 90 days past due will be referred to a collection agency; and our office may cease providing services to you.**
- **CHILD/CHILDREN'S VISITS: Responsibility for payment rests with the parent who seeks treatment. We do not send out duplicate statements to multiple parents or guardians. Court ordered judgements are between the individuals and do not include FOLSOM DERMATOLOGY.**
- **UNCOLLECTED PAYMENTS: If your payment to FOLSOM DERMATOLOGY is returned to us unpaid, we may elect to re-submit your payment to your financial institution and collect a return processing charge in an amount not to exceed that permitted by California state law.**

Patient Initials:_____ Date:_____

AGREEMENT

My signature below indicates that I have provided all requested information in the General, Physician, and Insurance sections and that I have read, understand, initialed, and dated the following:

- **CONSENTS for Patient Phone Messages, Sharing of Medical Information and Medical Photography**
- **AUTHORIZATIONS for ePrescribe, Pharmacy Benefits Manager, Special Accommodations, and (if applicable) Medicare Release and PPO & HMO Release.**
- **ACKNOWLEDGEMENTS for Receipt of Privacy Practices, Missed Appointments, and Financial Responsibilities.**

Patient Signature_____ **Initials**_____ **Date**_____

1745 CREEKSIDE DRIVE, FOLSOM, CA 95830
PHONE: (916) 983-2302

Health Information as of _____ (enter today's date)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge, (Please Print Legibly & Fill In or Correct All Fields)

Name:_____Reason for Visit:_____

Age: _____ Height:_____Feet_____Inches Weight:_____Lbs.

Race: _____ Ethnicity:_____ Language:_____

Who referred you to our office?_____

Who is your primary care physician?_____

What is your occupation?_____

Do you have or have you had any of the following: (check each;,If Yes, give date occurred)

Condition	No	Yes	Date	Condition	No	Yes	Date
Aids / HIV				Headaches / Migraine			
Arthritis				Heart Trouble			
Asthma				Hepatitis			
Bronchitis				High Blood Pressure			
Cancer				Headaches / Migraine			
Depression				Kidney Problems			
Diabetics				Pneumonia			
Dizziness / Vertigo				Sinus Problems /			
Ear Infection				Stroke			
Epilepsy / Seizures				Tonsillitis			
Facial Pain				Tuberculosis			
Fever Blisters				Ulcers			
Goiter / Thyroid				Other (List)			
Hay Fever /Allergies							

Activities

Do you exercise? ☐No ☐Yes If Yes, how much?_____Day(s)/Wk How long?_____Min ____Hrs
Do you smoke? ☐No ☐Yes If Yes, how much?_____Pack(s)/Day How long?_____Years
Do you drink alcohol ☐No ☐Yes If Yes, how much?_____ How often?_____
Do you use recreational drugs? ☐No ☐Yes If Yes, describe_____

Medical

Do you have bleeding or bruising problems ☐No ☐Yes If Yes, describe_____
Do you have problems with scarring ☐No ☐Yes If Yes, describe_____
Do you have any problems with anesthesia? ☐No ☐Yes If Yes, describe_____
Do you have an allergy to LATEX? ☐No ☐Yes If Yes, describe_____
Do you have any artificial joints? ☐No ☐Yes If Yes, location & when?_____
Have you ever been on cortisone or steroid treatment? ☐No ☐Yes
Do you have a Pacemaker? ☐No ☐Yes or Defibrillator? ☐No ☐Yes?

HEALTH INFORMATION for _____

Please list all present medications, including birth control pills, hormones, and vitamins, herbal medications, diuretics, weight loss drugs. Include over-the-counter medications.

Are you taking aspirin, Advil, Ibuprofen, or other pain relievers? ☐No ☐Yes If yes, describe_____

List ALL drug and/or latex allergies.

Skin

When you are exposed to the sun without sunscreen, do you ☐Tan ☐Burn, then tan ☐Burn only

Have you ever had skin cancers? ☐No ☐Yes If Yes, what kind?_____

Has anyone in your family ever had melanoma? ☐No ☐Yes If Yes, who?_____

Do you have a history of any skin diseases? ☐No ☐Yes If Yes, please list_____

The above information is accurate and complete to the best of my knowledge.

Signature_____ **Date**_____