



## NEW MINOR PATIENT REGISTRATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
First M.I. Last

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Marital Status:  Single  Married  Divorced  Widowed  Partner

Race: \_\_\_\_\_

Ethnicity: (Hispanic/Non-Hispanic, Latino/Non-Latino)

Mailing Address: \_\_\_\_\_  
City State Zip

Home Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Would you like to receive emails (Announcement, Specials and Promotions) from us? Yes/No

Occupation/Work Place: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Clinical Quality Measures: Height \_\_\_\_\_ Weight \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

- Family Member/Friend, if yes then who? \_\_\_\_\_
- Our Website
- Social Media, if yes then which site? \_\_\_\_\_
- Insurance
- Magazine/TV/Other Media (please indicate which one) \_\_\_\_\_
- Another Physician's Office (please indicate physician's name) \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_  
First M.I. Last

Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Payment Policy: The Parent/Guardian will be responsible for ALL copayments, we will not forward bills to other parties regardless of court rulings or divorce decrees.**

**PRIMARY/SECONDARY INSURANCE COVERAGE**

Primary Insurance Carrier: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

Name of Policy Holder (insured person) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

**May we leave medical information about the minor on you home voicemail and or email? Y/N**

**Do you give our office permission to discuss medical information with family members? Y/N**

**If yes: Name/relationship \_\_\_\_\_ Phone: \_\_\_\_\_**

**PLEASE REVIEW, COMPLETE AND INITIAL ALL OF THE FOLLOWING:**

**SSN# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_**

\_\_\_\_\_  
INITIALS If you call the office and request any information from your medical chart, you will be required to provide the office with the last four digits of your Social Security # before any information can be discussed.

\_\_\_\_\_  
INITIALS Any information relating to medical information from your chart (ie, test results) should be communicated on which phone numbers?

**HOME TELEPHONE \_\_\_\_\_ WORK TELEPHONE \_\_\_\_\_ CELL \_\_\_\_\_**

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. For those patients, applicable co-payments and deductibles will be collected. We accept in the form of cash, check, or credit card. In the event that your account must be turned over to collections, the patient responsibility is the actual cost of collections including but not limited to court/attorney fees. **If you need to reschedule or cancel an appointment, please notify us at least 48 hours in advance, or if you may subject to a \$25 LATE CANCELLATION fee for standard office visits and \$50 for procedure and cosmetic visits. Your signature below signifies your understanding and willingness to comply with this policy.**

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims.

A copy of this authorization may be used in the place of the original.

I understand and agree that I am financially responsible for all charges not paid by my insurance company. While we may participate with your insurance plan, it is your responsibility to be aware of your out of network insurance benefits.

This authorization may be revoked by either me or my insurance carrier at any time in writing.

**Patient or Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I have read and given a copy of the HIPAA Notice of Privacy Act and Patient Rights. Renascance Dermatology may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or other healthcare operations. Renascance Dermatology may mail to my home or other designated locations any items that assist the practice in carrying out treatment, payment or other healthcare operations.

By signing this form, I am consenting to Renascance Dermatology’s use and disclosure of my protected health information to carry out treatment, payment and other healthcare operations.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Patient’s Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Patient or Legal Guardian**

Please list below any person(s) and their relation to you that you authorize our office to speak with regarding your health care.

- 1. \_\_\_\_\_ Relation: \_\_\_\_\_
- 2. \_\_\_\_\_ Relation: \_\_\_\_\_
- 3. \_\_\_\_\_ Relation: \_\_\_\_\_
- 4. \_\_\_\_\_ Relation: \_\_\_\_\_

**PharmacyName:** \_\_\_\_\_

**Address/Zip Code:** \_\_\_\_\_

**Phone/Fax:** \_\_\_\_\_

### Past Medical History

- |  |   |
|--|---|
| <input type="checkbox"/> Anxiety                           | <input type="checkbox"/> Hypertension         |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> HIV/AIDS             |
| <input type="checkbox"/> Artificial Joints                 | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Hyperthyroidism      |
| <input type="checkbox"/> Atrial Fibrillation               | <input type="checkbox"/> Hypothyroidism       |
| <input type="checkbox"/> BPH(Benign Prostatic Hyperplasia) | <input type="checkbox"/> Leukemia             |
| <input type="checkbox"/> Bone Marrow Transplantation       | <input type="checkbox"/> Lung Cancer          |
| <input type="checkbox"/> Breast Cancer                     | <input type="checkbox"/> Lymphoma             |
| <input type="checkbox"/> Colon Cancer                      | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> COPD(emphysema)                   | <input type="checkbox"/> Prostate Cancer      |
| <input type="checkbox"/> Coronary Artery Disease           | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> End Stage Renal Disease           | <input type="checkbox"/> Valve Replacement    |
| <input type="checkbox"/> Gerd (Acid Reflux)                | <input type="checkbox"/> None                 |
| <input type="checkbox"/> Hearing Loss                      | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Hepatitis                         |   |

### Past Surgical History

- |   |   |
|---|---|
| <input type="checkbox"/> Appendix Removed                               | <input type="checkbox"/> Kidney Biopsy                              |
| <input type="checkbox"/> Bladder Removed                                | <input type="checkbox"/> Kidney Removed (right, left)               |
| <input type="checkbox"/> Mastectomy (right, left, bilateral)            | <input type="checkbox"/> Kidney Stone Removal (right, left)         |
| <input type="checkbox"/> Lumpectomy (right, left, bilateral)            | <input type="checkbox"/> Kidney Transplant                          |
| <input type="checkbox"/> Breast Biopsy                                  | <input type="checkbox"/> Ovaries Removed: Endometriosis             |
| <input type="checkbox"/> Breast Reduction                               | <input type="checkbox"/> Ovaries Removed: Cyst                      |
| <input type="checkbox"/> Breast Implants                                | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer            |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection              | <input type="checkbox"/> Prostate Removed: Prostate Cancer          |
| <input type="checkbox"/> Colectomy: Diverticulitis                      | <input type="checkbox"/> Prostate Biopsy                            |
| <input type="checkbox"/> Colectomy: IBD                                 | <input type="checkbox"/> TURP                                       |
| <input type="checkbox"/> Gallbladder Removed                            | <input type="checkbox"/> Skin Biopsy                                |
| <input type="checkbox"/> Coronary Artery Bypass                         | <input type="checkbox"/> Basal Cell Cancer Surgery                  |
| <input type="checkbox"/> PTCA   | <input type="checkbox"/> Squamous Cell Carcinoma Surgery            |
| <input type="checkbox"/> Mechanical Valve Replacement                   | <input type="checkbox"/> Melanoma Surgery                           |
| <input type="checkbox"/> Biological Valve Replacement                   | <input type="checkbox"/> Spleen removed                             |
| <input type="checkbox"/> Heart Transplant                               | <input type="checkbox"/> Testicles Removed (right, left, bilateral) |
| <input type="checkbox"/> Joint Replacement Knee (right, left bilateral) | <input type="checkbox"/> Hysterectomy: Fibroids                     |
| <input type="checkbox"/> Joint Replacement Hip (right, left, bilateral) | <input type="checkbox"/> Hysterectomy: Uterine Cancer               |

**Medications:** \_\_\_\_\_

\_\_\_\_\_

**Allergies:** \_\_\_\_\_

\_\_\_\_\_

**Skin Disease History**

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking/Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- None
- Other \_\_\_\_\_

**Review of Body History**

- Y/N Problems with Bleeding
- Y/N Problems with Healing
- Y/N Problems with Scarring (hypertrophic or keloid)
- Y/N Rash
- Y/N Immunosuppression
- Y/N Hay Fever
- Y/N Night Sweats
- Y/N Unintentional Weight Loss
- Y/N Cough
- Y/N Wheezing
- Y/N Anxiety
- Y/N Sore Throat
- Y/N Thyroid Problems
- Y/N Blurry Vision
- Y/N Abdominal Pain
- Y/N Bloody Stool
- Y/N Bloody Urine
- Y/N Joint Aches
- Y/N Muscle Weakness
- Y/N Neck Stiffness
- Y/N Fever or Chills
- Y/N Headaches
- Y/N Seizures
- Y/N Shortness of Breath
- Y/N Depression

**Social History**

**Smoking**

Smoker/Non Smoker/Former

**Alcohol Use**

Yes/No

**Language**

English/Spanish/Other

**How Often Do You Exercise?**

- Once a day
- A few times a week
- A few times a month
- Never

**Do You Wear Sunscreen?**

Yes What SPF? \_\_\_\_\_  
No

**Do You Tan?**

Yes/No

**What Is Your Caffeine Use**

- Once a day
- A few times a week
- A few times a month
- Never

**Do you have a family history of Melanoma? Y/N**

Yes/ Which Relatives \_\_\_\_\_

Any other family history \_\_\_\_\_