Renascance
DERMATOLOGY

NEW PATIENT REGISTRATION FORM

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:** _____

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: _____

PLEASE REVIEW, COMPLETE AND INITIAL ALL OF THE FOLLOWING:

SSN# _____ DATE OF BIRTH _____

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

_____ Any information relating to medical information from your chart (ie, test results) should be
INITIALS 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

__Anxiety
__Arthritis
__Artificial Joints
__Asthma
__Atrial Fibrillation
__BPH(Benign Prostatic Hyperplasia)
__Bone Marrow Transplantation
__Breast Cancer
__Colon Cancer
__COPD(emphysema)
__Coronary Artery Disease
__Depression
__Diabetes
__End Stage Renal Disease
__Gerd (Acid Reflux)
__Hearing Loss
__Hepatitis
__Hypertension
__HIV/AIDS
__Hypercholesterolemia
__Hyperthyroidism
__Hypothyroidism
__Leukemia
__Lung Cancer
__Lymphoma
__Pacemaker
__Prostate Cancer
__Radiation Treatment
__Seizures
__Stroke
__Valve Replacement
__None
__Other_____

Past Surgical History

__Appendix Removed
__Bladder Removed
__Mastectomy (right, left, bilateral)
__Lumpectomy (right, left, bilateral)
__Breast Biopsy
__Breast Reduction
__Breast Implants
__Colectomy: Colon Cancer Resection
__Colectomy: Diverticulitis
__Colectomy: IBD
__Gallbladder Removed
__Coronary Artery Bypass
__PTCA
__Mechanical Valve Replacement
__Biological Valve Replacement
__Heart Transplant
__Joint Replacement Knee (right, left bilateral)
__Joint Replacement Hip (right, left, bilateral)
__Kidney Biopsy
__Kidney Removed (right, left)
__Kidney Stone Removal (right, left)
__Kidney Transplant
__Ovaries Removed: Endometriosis
__Ovaries Removed: Cyst
__Ovaries Removed: Ovarian Cancer
__Prostate Removed: Prostate Cancer
__Prostate Biopsy
__TURP
__Skin Biopsy
__Basal Cell Cancer Surgery
__Squamous Cell Carcinoma Surgery
__Melanoma Surgery
__Spleen removed
__Testicles Removed (right, left, bilateral)
__Hysterectomy: Fibroids
__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

Do You Wear Sunscreen?
Yes What SPF? _____
No

Do You Tan?
Yes/No

How Often Do You Exercise?
Once a day
A few times a week
A few times a month
Never

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_____