PALM BEACH DERMATOLOGY, INC. - REGISTRATION FORM

NAME: _____ HOME PHONE: _____
LAST FIRST MI

PERMANENT (LOCAL) ADDRESS: _____

HOME FAX# :_____ CELLULAR#:_____ EMAIL:_____

*CITY:*_____ *STATE:*_____ *ZIP:*_____

OUT OF STATE ADDRESS: _____*CITY:*_____ *STATE:*_____ *ZIP:*_____

OUT OF STATE PHONE NUMBER: _____

AGE: _____ DATE OF BIRTH: _____ SEX: M OR F SOCIAL SEC. #: _____
mo/day/year

OCCUPATION: _____ BUSINESS PHONE #: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT PHONE # & ADDRESS: _____

SPOUSE / PARENT: _____ADDRESS: _____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN SELF: _____

ADDRESS:_____ PHONE:_____

MEDICARE NUMBER: _____

NAME OF SUPPLEMENTAL CARRIER: _____ POLICY #: _____

ADDRESS: _____ PHONE: _____

INSURANCE CARRIER: _____ PHONE: _____

ADDRESS: _____

POL. #: _____ GROUP #: _____

PAYMENT IS TO BE MADE AT THE TIME SERVICES ARE RENDERED.

LIFETIME SIGNATURE AUTHORIZATION: I authorize the physicians and assistants of Palm Beach Dermatology, Inc. to administer medical care as deemed necessary. I authorize the release of any medical information requested by my insurance carrier in order to process insurance claims.
I understand I am personally responsible for all fees (including deductibles and copayments) incurred for services rendered to me or my child.

SIGNATURE: _____ DATE: _____
Parent or Guardian to sign if patient is a minor

MEDICARE PATIENTS: I request payment of authorized Medicare benefits be made either to me or on my behalf to Palm Beach Dermatology, Inc., for any services furnished me by that physician/clinic. I understand that I am fully responsible for any yearly deductible and/or coinsurance balance due after Medicare. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

SIGNATURE: _____ DATE: _____
Parent or Guardian to sign if patient is a minor

MANAGED CARE AND PREFERRED PROVIDER ORGANIZATION (HMO/PPO) PATIENTS: I understand that I am responsible for all deductibles and co-payments at the time of service. I further understand that should payment be denied due to **"PRE EXISITING ILLNESS", NON-COVERED OR TERMINATION OF COVERAGE,** I will be responsible for payment of such fees within 10 days of such notification.

SIGNATURE: _____ DATE: _____
Parent or Guardian to sign if patient is a minor

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify I have had the opportunity to review/receive a copy of PBD & P, Inc.'s Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information which might occur in order to expedite medical treatment, payment of medical claims, or facility health care operations.

SIGNATURE: _____ DATE: _____
Parent or Guardian to sign if patient is a minor

MEDICAL HISTORY
(PLEASE ANSWER ALL QUESTIONS)

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Bleeding Disorders ____ Diabetes ____ Glaucoma ____ Hepatitis ____ Ulcers____ High Blood Pressure ____

Tuberculosis ____ Heart Attack/Stroke ____ Heart Pacemaker ____ Venereal Diseases ____ AIDS/HIV ____

Asthma ____ Psoriasis ____ Malignant Melanoma ____ Skin Cancer ____ Eczema ____

Penicillin Allergy: _____ **Allergies to other medications or anesthetics**: _____

List ALL other known allergies: _____

Do you have an artificial heart valve? Yes ____ No ____

Have you had joint replacement surgery? Yes ____ No ____

Do you have a family history of skin cancer? Yes ____ No ____

If YES, please indicate type of cancer：_____

List **ALL** Medications you are currently taking ***including*** over the counter medications, skin medications, multi-vitamins, birth control, blood thinners, and hormone therapy, aspirin, laxatives.

_____

_____

Recent operations (Last 3 Years)

_____

FEMALE PATIENTS: Are you pregnant? Yes ____ No ____ Planning to get pregnant? Yes ____ No ____

Are you breast feeding? Yes ____ No ____ Have you taken birth control pills? Yes ____ No ____

Briefly describe your current skin problem : _____

How long have you had your present skin problem?:_____

Indicate on the diagram the affected part(s) of your body.