Premier Dermatology

Patient Registration (Please Print) Today's date ___/___/___

Date of Birth _____/_____/_____ Gender: **Male or Female**

Name: _____ _____ _____
Last First M.I.

Mailing Address: _____

_____ _____ _____
City State Zip Code

Home Phone: _____ **Email address**: _____

Cell Phone: _____

Marital Status (circle) - Single / Married / Domestic Partnership / Divorced / Separated / Widow

Race (circle all that apply) -

-American Indian/Native Alaskan -Asian -Black or African American
-Native Hawaiian/Pacific Islander -White -Declined to specify

Ethnicity (circle) - Non-Hispanic/Latino or Hispanic/Latino or Decline to specify

Language (circle) - English / Spanish / Korean / Other:_____

Occupation: _____ Employer:_____ Work# _____

IF PATIENT IS A MINOR:

Parent/Guardian Name _____ Parent/Guardian DOB: _____

Relationship to Patient: _____

Parent/Guardian Signature _____ Date: _____

Insurance Information (please present insurance card at time of check in)

Primary Insurance Name:_____ **Secondary Insurance Name:_____**
Policy Holder's Name:_____ **Policy Holder's Name: _____**
Policy Holder's DOB: _____ **Policy Holder's DOB: _____**
Relationship to Patient: _____ **Relationship to Patient: _____**

Primary Care Physician_____phone#_____
Preferred Local Pharmacy_____
Address_____phone#_____
Mail away pharmacy_____

Medical History

Past Medical History:

(please circle all that apply or list in space provided)

None
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH
Breast Cancer – year_____
Colon Cancer – year _____
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
HIV/AIDS
Hypercholestemia (High Cholesterol)
Hypertension (High Blood Pressure)
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer - year _____
Lymphoma – year _____
Prostate Cancer - year _____
Radiation Treatment – year _____
Seizures
Stroke
Other: _____
_____
_____

Past Surgical History:

(please circle all that apply or list in space provided)

None
Appendix Removed (Appendectomy)
Bladder Removed (Cystectomy)
Breast Biopsy
Breast Lumpectomy (Right, Left, Both)
Breast Mastectomy (Right, Left, Both)
Colectomy – (Diverticulitis, IBD)
Colon Cancer Resection
Colon- Colostomy
Gallbladder Removed (cholecystectomy)
Heart- Biological Valve Replacement
Heart- Coronary Artery Bypass Surgery
Heart- Mechanical Valve Replacement
Heart- PTCA(angioplasty)
Heart Transplant
Joint Replacement -Hip (Right, Left, Both)
Joint Replacement – Knee (Right, Left, Both)
Kidney Removal (Nephrectomy)
Kidney Stone Removal
Kidney Transplant
Liver Removal (Hepatectomy)
Liver Transplant
Ovaries Removed – Ovarian Cancer
Ovaries Removed- (Endometriosis, Ovarian Cyst)
Ovaries Removed – Tubal Ligation
Pancreas Removal (Pancreatectomy)
Prostate Removal (Prostatectomy)
Prostate -TURP
Rectum- Lower Anterior Resection
Spleen Removed (Splenectomy)
Testicles Removed (Orchiectomy)
Uterus Removed-Hysterectomy- Fibroids
Uterus Removed-Hysterectomy- Cervical Cancer
Uterus Removed-Hysterectomy- Uterine Cancer
Other:_____
_____

Skin Disease History:

(please circle all that apply or list in space provided)

None
Acne
Actinic Keratoses
Flaking or Itching Scalp
Hay Fever / Allergies
Melanoma-year_____

Asthma
Basal Cell Carcinoma- year_____
Blistering Sunburns
Dry Skin
Eczema
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma- year_____
Other: _____

Do you wear sunscreen? **YES or NO** If yes, what SPF? _____
Do you tan in a tanning salon? **YES or NO**
Do you have a family history of Melanoma? **YES or NO** If yes, what relative? _____

Medications: (please list all current medications or attach list)

_____
_____
_____
_____
_____

Allergies to Medications: (please list allergies and reactions you get)

_____
_____

Immunizations:

Have you received a flu vaccine this season? **YES or NO**
Have you ever received the Pneumonia vaccine? **YES or NO**
Have you ever received the Shingles vaccine? **YES or NO**

Social History: (please circle all that apply)

Smoking Status:
Never smoker
Former smoker – Date quit_____
Current some day smoker
Current every day smoker

Alcohol Consumption:
None
Less than 1 drink per day
1-3 drinks per day
3-4 drinks per day

Family History:

(please circle all that apply and list first degree relative that applies to)

Melanoma- _____
Non-Melanoma Skin Cancer-_____
High Cholesterol-_____
High Blood Pressure-_____
Thyroid Disease-_____
Diabetes-_____
Other Cancers (type)-_____
_____

If over the age of 65, do you have a health care proxy to make medical decisions for you in the case of an emergency? YES or NO
If yes, please list name and contact number:_____
Do you have a living will? YES or NO

Cautions/Alerts: (please circle all that apply)

-Pregnancy or planning a pregnancy
-Allergy to adhesive
-Allergy to topical antibiotic ointments
-Allergy to Lidocaine
-Rapid heartbeat with epinephrine
-Premedication prior to procedures
-Artificial heart valve
-Organ transplants
-Artificial joints within past 2 years
-Blood thinners
-Defibrillator
-Pacemaker
-History of MRSA
-History of vasovagal response after stress or procedures
-Other-_____

Primary Care Physician: _____ phone# _____

Preferred Local Pharmacy: _____
address:_____ phone# _____

Mail Away Pharmacy: _____

PREMIER DERMATOLOGY

Patients Name: _____DOB:_____

Authorization for Treatment & Payment of Medical Benefits Patient Financial Responsibility

Thank you for choosing our practice, Premier Dermatology, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, Premier Dermatology, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, Dr. Chung Chung, MDPC aka Premier Dermatology.

Use of Photography-I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

Patient Financial Responsibilities

- I (or patient's gaurdian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am resposible for, the payment of additional charges. These charges may include (but are not limited to): Charge for returned checks.

Patient Authorizations

- By my signature below, I hereby authorize the practice, Premier Dermatology, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, Premier Dermatology. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

HIPAA-In addition to the above financial statement, I have reviewed a copy of the HIPAA privacy policy posted in the main office and can receive a copy at my request.

I hereby give my permission to disclose health information (i.e. test results) about me to the following people:

•Spouse_____# _____

• Family_____#_____

Relationship _____

•Other_____#_____

Signature of Patient or Guardian

_____Date_____