

Woodbury 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 _____

Medical History

Past Medical History:

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

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

Past Surgical History:

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

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

Skin Disease History:

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

None	Flaking or Itching Scalp
Acne	Hay Fever / Allergies
Actinic Keratoses	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: _____

WOODBURY DERMATOLOGY

Patients Name: _____DOB: _____

Authorization for Treatment & Payment of Medical Benefits Patient Financial Responsibility

Thank you for choosing our practice, Woodbury 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, Woodbury 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 Woodbury 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 guardian, 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 responsible 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, Woodbury 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, Woodbury 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_____