PATIENT REGISTRATION FORM
(Please Print)

Last:_______________________ Address:____________________
First:_______________________ City:________________________
Middle:_____________________ State:__________Zip:__________
Birthdate:____________Sex____ Home#______________________
S.S.#_______________________ Cell#_______________________
Spouse B/Date_______________ Emergency#__________________
Spouse S.S.#________________ Primary Physician_____________

Employment Information
Employer:__________________ Work #______________________
Occupation_________________

For Patients Under 18 Years of Age
Guardian:__________________ Relation to Pt:________________
Home#_____________________ Work#_______________________

Insurance Information

Primary:____________________ Secondary:___________________
Subscriber Subscriber
Name:______________________ Name:_______________________
ID#________________________ ID#_________________________
Birthdate:__________________ Birthdate:___________________
Relation of Pt:______________ Relation to Pt:_______________

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescription. I also authorize payment of medical benefits to the physician.

Patient Signature ________________________________ **Date**______________

In order to establish optimal relations with our patients and avoid misunderstandings 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 unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office may file with appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that you have an insurance that requires referrals, the proper referral must be presented prior to the time of service. In the event that your account must be turned over to collections, a $10.00 collections fee will be added to your account. Your signature below signifies your understanding and willingness to comply with our office policies

Patient Signature________________________________ **Date**________________

Print Name____

If you are Medicare, please fill in the information below and sign

PATIENT REQUEST FOR PAYMENT

Patient Name____

Medicare ID#____

I request that payment of authorized Medicare benefits be made either to me or on my behalf, to the practice of Dr. Grace Chung, MDPC for services furnished me by any of the doctors of said practice.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

____
Signature of Patient or authorized agent

____
Date

Grace U. Chung, M.D.
Kenneth Herman, D.O.
Kehua Li, M.D.
Shelly Schneider, APN

Dermatology
Dermatologic Surgery
Phone: 856-853-0900
Fax: 856-853-5838

Woodbury Medical Center
17 W. Red Bank Ave, Suite 205
Woodbury, NJ 08096

HIPAA NOTICE FOR PRIVACY PRACTICES

We are required by law to maintain the privacy of Protected Health Information and provide individuals with this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main number.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

By signing this form, you are also allowing our office to:

1. Confirm appointments at your home by phone or answering machine;
2. Disclose medical information requested by other treating physicians;
3. Leave messages or discuss medical information with your pharmacist;
4. Disclose medical information to you/lab/insurance company;
5. Request medical records when necessary from physicians or health care facilities.

I hereby give my permission to disclose health information (i.e. test results) about me to the following people: (please print name and telephone # on line provided)

Spouse__________________________ **Telephone #**______________________

Son/Daughter_____________________ **Telephone#**________________________

Mother/Father____________________ **Telephone#**________________________

Other____________________________ **Telephone #**________________________

Can we leave medical results on your Answering Machine? YES NO

I have the right to withdraw or revise my permission at any time, in writing.

Print Patient's Name____

Signature__________________________________**Date**______________________

(Parent/Guardian Signature if patient is under 18 yrs of age.)

NAME:________________________ DATE OF BIRTH______________

Social History: (Please circle one)

Cigarette Smoker:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol use:
YES
NO

Language:
English
Spanish
Other__________

How often do you exercise?
Once a day
A few times a week
Never

What is your caffeine use?
Once a day
A few times a week
Never

Marital Status

Single   Married   Divorced   Widowed

Method of contact
Phone:
Home____________________
Cell____________________
Work____________________
Email____________________
Is it ok to leave detailed messages and/or appointment reminders?
YES   NO

Race
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity
Hispanic/Latino
Non-Hispanic/Latino

Pharmacy & Location

____

____

Skin Disease: (please circle all that apply)

Acne	Hay Fever/Allergies
Actinic Keratosis	Melanoma
Asthma	Poison Ivy
Basal Cell Carcinoma	Precancerous Moles
Blistering Sunburn	Psoriasis
Dry Skin	Squamous Cell Carcinoma
Eczema	None
Flaking or Itchy Scalp	

Other_______________________________________

Do you wear Sunscreen? Yes No
If yes, what SPF______________

Do you tan in a tanning salon? Yes No

FAMILY HISTORY: Please circle any that apply

Melanoma: Mom Dad Brother Sister Son Daughter

Non Melanoma: Mom Dad Brother Sister Son Daughter

High Cholesterol: Mom Dad Brother Sister Son Daughter

High Blood Pressure: Mom Dad Brother Sister Son Daughter

Thyroid Disease: Mom Dad Bother Sister Son Daughter

Diabetes: Mom Dad Brother Sister Son Daughter

MEDICATIONS: Please enter current medications and dosage

____

____

____

ALLERGIES TO MEDICATIONS:

____

____

____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH(benign prostate hyperplasia)
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
Other____________________
NONE

Past Surgical History: (please circle all that apply)

Appendix
Bladder Removed
Breast Mastectomy
(right, left, bialateral)
Breast Lumpectomy
(right, left, bialateral)
Breast Biopsy
(right, left, bialateral)
Breast Reduction
Breast Implants
Colon:Colectomy:Resection
Colon:Colectomy:Diverticulitis
Colectomy:IBD
Gallbladder Removed
Coronary Bypass
Joint Replacement____________
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Kidney Biopsy
Kidney Removed
Kidney Stone Removed
Kidney Transplant
Ovaries Removed:
(endometriosis, cyst, cancer)
Prostate Removed
Prostate Biopsy
TURP
Basal Cell Cancer Surgery
Squamous Cell Cancer Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed
Hysterectomy:Fibroids
Hysterectomy:Uterine Cancer

NONE