LAUDERDALE ACADEMIC DERMATOLOGY

PATIENT REGISTRATION FORM

Today's Date: _____/_____/_____

Title: ○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Miss.

Name: _____ ○ Jr. ○ Sr.
First Middle Last

Address: _____
Number Street Name Apt. Number City State Zip

Employer: _____
Name Address

Home Phone: _____ Work Phone: _____ Date of Birth: ____/_____/____

Social Security Number (required): _____ Sex: ○ M ○ F

Preferred Contact Number: ○ Home ○ Work ○ Cell: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed ○ Partnered

Name of Spouse/Significant Other/Partner: _____

Parent or Responsible Party (Guarantor)

Name: _____ ○ Jr. ○ Sr.
First Middle Last

Address: _____
Number Street Name Apt. Number City State Zip

Employer: _____
Name Address

Home Phone: _____ Work Phone:_____ Date of Birth ____/_____/____

Social Security Number: _____Sex: ○ M ○ F

If Student: ○ Full Time ○ Part Time Name of School:_____

Please present all insurance cards and photo ID to the receptionist so copies may be made.

Continue→

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PATIENT REGISTRATION FORM (continued)

In case of emergency, who should be notified: _____Phone_____

Referring Physician/Provider: _____

Primary Care Physician/Provider: _____

Attestation

I authorize the release of medical information to my primary care or referring physician, to consultant if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I authorize payment of medical benefits to physicians. I have received a copy of the HIPAA regulations or Notice of Privacy Practices:

In order to establish optimal relations with out patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE. For insured patients, applicable co-payments and deductibles will be collected. Insurance coverage can be pre-verified, and you will be asked to pay any unmet deductible, non-covered services, and co-payments. However, the EOB (explanations of benefits) form of your insurance may show un-paid deductibles and co-payments and you will be billed for those charges that are your responsibility according to the terms of your policy. In the event that your account must be turned over to collections, a $10 collection fee will be added to your account. A returned check will incur a $25 processing penalty from this office. Your signature below indicates that you understand and accept this policy.

Patient or Responsible Party Signature: _____

Date: _____

LAUDERDALE ACADEMIC DERMATOLOGY

Medical Questionnaire

Today's Date: _____/_____/_____

List all Allergies: *(Write NONE, if none)*

_____

List all Current Medications: *(Write NONE, if none)*

_____

_____

Reason for Today's Visit: (*include duration of problem and previous treatments*)

_____

_____

_____

_____

Any Past Skin Problems: *Circle all that apply to you*: •skin cancer•**MELANOMA**•childhood blistering sunburns•psoriasis•eczema:

Details:_____

_____

_____

Current or Past Problems with:

	YES	NO	Explain if **YES** *(may list Surgeries here)*
General Health	☐	☐	_____
Cancer	☐	☐	_____
Eyes	☐	☐	_____
Ears/Nose	☐	☐	_____
Throat/Mouth	☐	☐	_____
Heart	☐	☐	_____
Lungs	☐	☐	_____
Stomach/Bowels	☐	☐	_____
Kidneys	☐	☐	_____
Arthritis/Muscles/Joints	☐	☐	_____
Headaches/Seizures	☐	☐	_____
Psychological Disorder	☐	☐	_____
Thyroid/Diabetes	☐	☐	_____
Blood/Bleeding Disorder	☐	☐	_____

Continue→

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Medical Questionnaire *(continued)*

	YES	NO	Explain if **YES** *(may list Surgeries here)*
Blood/Bleeding Disorder	☐	☐	_____
Allergic/Immunologic	☐	☐	_____
HIV+/Hepatitis B or C	☐	☐	_____
Transplants/Implants	☐	☐	_____

List All Surgeries and Operations:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Females: •Are you pregnant? ___Yes ___No •Planning to become pregnant? ___Yes ____No
•Nursing ___ Yes ___ No

Family History: *(Past Family and Social History)*

Mother: living or deceased of _____ at age _____
Father: living or deceased of _____ at age _____
Number of your children: _____ age(s) _____

Check the following medical conditions that have occurred in your family:

DISEASE	Mother	Father	Blood Relative
Allergies/hayfever/asthma	O	O	O
Arthritis	O	O	O
Cancer	O	O	O
Diabetes	O	O	O
Eczema	O	O	O
Heart Disease	O	O	O
High Blood Pressure	O	O	O
Malignant Melanoma	O	O	O
Psoriasis	O	O	O
Skin cancer	O	O	O
Tuberculosis	O	O	O

Social History

Do you use sunscreens? ____ No ___ Daily ___ Sometimes Do you smoke? ____ No _____Yes
Do you drink alcohol? _____ No ____Yes Occupation _____
Hobbies/Leisure activities _____

Reviewed _____ Date _____
(MD signature)