PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Name (as it appears on Driver's License or Photo ID): **First Middle Last**	**Patient Date of Birth (MM/DD/YYYY):**
	Social Security Number:
Mailing Address (Street, City, State, ZIP):	**Patient Gender (circle): Male | Female**
	Marital Status:
Email Address:	**Occupation:**
Home Phone Number:	**Employer:**
Cell Phone Number:	**Employer Phone Number:**
Referred to Clinic By (Please circle): **Dr. _____ | Family / Friend | Insurance Company | Web Search | Print Ad | Other:_____**	
Primary Care Physician (PCP) Name:	**PCP Phone Number (if known):**

RESPONSIBLE PARTY INFORMATION (Spouse / Parent / Legal Guardian)

Guarantor on Account (eg, responsible parent if patient is a minor):	**Guarantor Phone Number:**	**Guarantor Relationship to Patient:**
Guarantor Date of Birth (MM/DD/YYYY):	**Guarantor Mailing Address (Street, City, State, ZIP):**	

INSURANCE INFORMATION

Primary Insurance Company:	**Policy/ID Number:**	**Group Number:**
Policyholder's Name:	**Policyholder's Date of Birth:**	**Relationship to Patient:**
Specialist Copay Amount: $_____		
Secondary Insurance Company:	**Policy/ID Number:**	**Group Number:**
Policyholder's Name:	**Policyholder's Date of Birth:**	**Relationship to Patient:**

EMERGENCY CONTACT (Please list anyone you authorize to receive protected health information)

Name:	**Relationship to Patient:**	**Phone Number:**

LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Epiphany Dermatology and its related companies. I understand that I am financially responsible for any balance. I also authorize Epiphany Dermatology, its related companies, or insurance company to release medical information required to process claims.
Notice of Privacy Practices: I have read or been offered a copy of Epiphany Dermatology's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.
Consent for Communication: I understand Epiphany Dermatology will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.
Payment Policy: Payment is due at time of service, including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Epiphany Dermatology and its related companies.
Legal: This form applies to Epiphany Dermatology and its related companies.

SIGNATURE

Patient / Guardian Signature:	**Date:**

Medical History and Intake Form

Patient Name: _____

Date of Birth (MM/DD/YYYY): _____

Reason for visit, location of problem, duration of problem: _____

_____

Past Medical History: (Check all that apply. If NONE, please check NONE)

- o Allergies (Seasonal)
- o Asthma
- o Bleeding Disorder (or bleeding issue)
- o Cancer:_____
- o Coronary Artery Bypass
- o Depression
- o Diabetes
- o Fever Blister
- o Heart Valve Replacement
- o High Blood Pressure
- o High Cholesterol
- o HIV/AIDS
- o Joint Replacement
- o Kidney Transplant
- o Liver Disease
- o Lumpectomy
- o Lupus / Rheumatoid Arthritis
- o Mastectomy
- o Organ Transplant
- o Thyroid Disease
- o **NONE**

Do you have a history of Skin Cancer or Skin Disorders? (Examples: acne, actinic keratosis, basal cell, melanoma, psoriasis, squamous cell) Yes_____ No_____ If yes, please indicate condition or disorder:

_____

Family History of Skin Cancer including Melanoma? Yes _____ No_____

If yes, whom: _____

Medications: (Enter all current medications including non-prescription and birth control; if none mark N/A)

_____

Allergies: (Please enter all allergies including allergy to medications; if none mark N/A)

_____

Social History:

Do you smoke? Yes___ No___ If yes, how much?_____ Do you drink alcohol? Yes___ No___ If yes, how much?_____

Review of Systems: (Check all that apply)

- o Problems with bleeding
- o Problems with healing
- o Problems with scarring/keloids
- o Fever or Chills
- o Night sweats
- o Unintentional weight loss
- o Joint pain

Alerts: (Check all that apply. If NONE, please check NONE)

- o Allergy to Adhesive
- o Allergy to Lidocaine
- o Allergy to Topical Antibiotics
- o Artificial Heart Valve
- o Artificial Joint Replacement
- o Blood Thinners
- o Defibrillator
- o MRSA
- o Pacemaker
- o Require antibiotics prior to a surgical procedure
- o Rapid heart beat with Epinephrine
- o Are you pregnant or currently trying to get pregnant?
- o Breastfeeding
- o **NONE**

Preferred Pharmacy Name: _____ **Telephone (if known):** _____

Address (or cross streets):_____ **City:** _____