

Name: _____

Date of Birth: _____

Appt. Date: _____

(for office use—MR#: _____)

PATIENT REGISTRATION

PLEASE PRINT

NAME (Last, First, MI) _____

PREFERRED NAME _____

ADDRESS (Street or P.O. Box) _____

ADDRESS (City, State Zip Code) _____

PHONE: **H** _____ **C** _____ **W** _____

E-MAIL _____

SEX _____ DATE OF BIRTH (MM/DD/YR) _____

PRIMARY CARE MD _____ CITY/STATE _____

REFERRING MD _____ CITY/STATE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE # **H** _____ **W** _____ **C** _____

EMPLOYER _____ OCCUPATION _____

COLLEGE STUDENT FT PT SCHOOL NAME: _____

SEND BILL TO (IF DIFFERENT FROM PATIENT)

NAME (Last, First, MI) _____

ADDRESS (Street or P.O. Box) _____

ADDRESS (City, State Zip Code) _____

PHONE: **H** _____ **W** _____ **C** _____

RESPONSIBLE PARTY'S RELATIONSHIP TO PATIENT _____

PRIMARY INSURANCE COMPANY NAME _____ **CO-PAY** \$ _____

NAME OF POLICY OWNER (Last, First, MI) _____

IDENTIFICATION # _____ GROUP # _____

PATIENT RELATIONSHIP TO POLICY OWNER _____

POLICY OWNER'S DATE OF BIRTH _____

SECONDARY INSURANCE COMPANY NAME _____ **CO-PAY** \$ _____

NAME OF POLICY OWNER (Last, First, MI) _____

IDENTIFICATION # _____ GROUP # _____

PATIENT RELATIONSHIP TO POLICY OWNER _____

POLICY OWNER'S DATE OF BIRTH _____

PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST SO THAT COPIES MAY BE MADE

Name: _____

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The physicians and staff of New England Dermatology & Laser Center value and appreciate your selection of our office for your skin care. We are committed to providing you with the best possible service. A clear understanding of our office policy is important to our professional relationship.

INSURANCE AND MANAGED CARE

We participate in most insurance plans. Please inquire upon check-in to see if we accept your plan to avoid billing problems later. If your insurance plan requires a referral, you must have a valid referral on file from your primary care physician. If your visit has not been authorized, you have the option of signing a waiver making you financially responsible for that visit or rescheduling your appointment until such time as your visit is authorized.

APPOINTMENT CANCELING/NO-SHOW

If you cannot keep your scheduled appointment, please call within 24 hours to cancel it. We reserve the right to charge a fee for appointments that are not canceled within a reasonable time frame. If repeated "NO-SHOWS" occur, you will be discharged from care.

Please initial _____.

COSMETIC REMOVAL OF BENIGN LESIONS

A benign lesion is a spot or growth which in the physician's opinion is not cancerous or pre-cancerous and for which there is no medical reason to treat. Insurance companies will pay for the evaluation of these lesions, but will not pay for their removal. Lesions which may fall into this category include: certain moles, brown spots (so called "liver" or "age" spots), angiomas (blood vessel moles and "broken" blood vessels), seborrheic keratoses (wartlike moles), skin tags (small flaps of skin found around eyelids, neck, under arms, under breasts, and in groin), and milia (persistent whiteheads) on face and eyelids. If you have a benign growth which you would like to have removed, you must sign a "waiver of liability" agreeing to be personally and financially responsible and payment is expected at the time of treatment.

If you have any questions, please feel free to inquire before signing below.

I have read and understand the above policies.

Patient signature _____ Date _____

Guarantor signature (if guarantor is not the patient) _____ Date _____

Name: _____

Date of Birth: _____

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PATIENT CONSENT FOR TREATMENT, PAYMENT, TO SHARE HEALTH INFORMATION FOR LIMITED PURPOSES AND FOR PHOTOGRAPHS

ALL PATIENTS:

- I hereby authorize medical/surgical treatment, care and/or services by New England Dermatology & Laser Center.
- I hereby authorize payment directly to New England Dermatology & Laser Center for all medical/surgical benefits, if any, that may be payable to me under the terms of my health insurance policy.
- I fully understand that I am primarily and financially responsible for fees incurred. I further understand that payment to New England Dermatology & Laser Center is not contingent on any settlement, judgment, or verdict by which I eventually recover medical fees.
- I hereby consent to and authorize New England Dermatology & Laser Center to use and disclose any of my health information, including my medical records and prescription medical history, for purposes concerning my treatment, payment for health care provided to me or the health care operations of New England Dermatology & Laser Center or other treating health care provider or plan.

Signature of patient or guardian _____ Date _____

MEDICARE PATIENTS ONLY:

I authorize any holder of medical and other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply.

Signature of patient or guardian _____ Date _____

MEDICARE SUPPLEMENTAL PATIENTS ONLY:

If you have a supplemental policy to which Medicare automatically crosses over, we are required to keep a separate signature on file. I request authorized supplemental policy benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Signature of patient or guardian _____ Date _____

PHOTOGRAPHS:

I give New England Dermatology & Laser Center permission to take clinical photographs for my medical record. I understand that the photographs remain the property of the office and may be used for the purpose of furthering medical education.

Signature of patient or guardian _____ Date _____

Name: _____

Date of Birth: _____

Appt. Date: _____

(for office use—MR#: _____)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

It is the policy of New England Dermatology & Laser Center to provide all patients, or their parents, guardians or personal representatives, a copy of our current Notice of Privacy Practices prior to the date of the first service delivery, or upon the first visit to New England Dermatology & Laser Center after April 14, 2003, if feasible. This signed acknowledgement is to be filed in the medical record.

Patient's Name: _____

I have received New England Dermatology & Laser Center's Notice of Privacy Practices. (If the patient is a minor or is unable to sign for him or herself, then a parent, guardian or personal representative should sign on the patient's behalf.)

Patient or guardian signature: _____ Date _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND/OR OTHER REPRESENTATIVES

By signing below, I have authorized New England Dermatology & Laser Center to disclose my Protected Health Information to the following family and friends:

NAME	RELATIONSHIP	TELEPHONE #

Please complete your personal contact information below in order for us to reach you if needed:

Home _____ May we leave a message on your answering machine? Y or N

Work _____ May we leave a message on your voice mail? Y or N

Cell _____ May we leave a message on your voice mail? Y or N

E-mail _____ May we leave you an e-mail message? Y or N

You are required to state how long this consent is valid: _____ one year; _____ two years; _____ three years

You may revoke this authorization at any time by stating in **writing** to the Privacy Officer at New England Dermatology & Laser Center.

Patient or guardian signature: _____ Date _____

Name: _____

Date of Birth: _____

Appt. Date: _____

(for office use—MR#: _____)

(for office use--Initial HX ___ Updated HX ___)

REVIEW OF SYSTEMS

Who is your Primary Care Physician? _____

Have you ever been a patient in our office? Yes No If yes, how long ago? _____

What WAS the reason? _____

What IS the reason for your visit today? _____

Are you ALLERGIC or have you had ADVERSE REACTIONS to any MEDICATIONS, FOODS, LATEX OR RUBBER, or other products? Yes No If yes, please list and explain. _____

List ALL MEDICATIONS, PRESCRIPTIONS, and/or NON-PRESCRIPTION drugs (including herbal medications, aspirin, birth control pills, hormones, allergy shots, vitamin, laxatives, pills for headache, arthritis, nerves, sleeping, pain, etc.) that you take daily. _____ No Medications

Please CIRCLE any of the following MEDICAL PROBLEMS you have or have had. List any others.

HEART: High blood pressure, angina, heart attack, heart murmur, irregular heart beat, pacemaker

LUNG: Bronchitis, emphysema

STOMACH, BOWEL or LIVER: Ulcers, colitis, diverticulitis, irritable bowel

KIDNEY DISEASE:

GYNECOLOGICAL: Irregular menstrual cycles

METABOLIC: Diabetes, thyroid

NEUROLOGIC: Migraine headaches, convulsions, stroke

MENTAL HEALTH COUNSELING: Was medication prescribed? _____ Yes _____ No

BLOOD: Bleeding, anemia

ARTHRITIS: Rheumatoid, osteoarthritis, psoriatic, lupus

BONE/JOINT IMPLANTS: Artificial knee, hip, metal pins, etc.

VASCULAR: Varicose veins or blood clots in legs

EYES: Glasses, contact lenses, glaucoma, cataracts, lens implants

EARS: Hearing aid

ALLERGIES: Asthma, hay fever, sinus, hives

INFECTIOUS DISEASES: Hepatitis, Tuberculosis, HIV, other

CANCER: Type: _____

Treatment: Radiation Chemotherapy Year of Treatment: _____

List Surgery & Year of Treatment: _____

OTHER DISEASES: _____

Name: _____

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Are you pregnant or could you be pregnant? Yes No

After injury or surgery, have your scars healed satisfactorily? Yes No

Have you or any family members had bleeding problems with dental procedures or surgery? Yes No

Have you ever had a reaction to locally injected anesthesia (Novocaine/Xylocaine) similar to that which you may receive at the dentist? If yes, please explain: _____ Yes No

Have you had skin reactions to band aids, adhesive tape, antibiotic ointments or topical creams? Yes No

Have you ever fainted? If yes, what were the circumstances? _____ Yes No

Prior to dental procedures or surgery, have you been advised to take antibiotics because of a heart problem, artificial joint implant or other reason? Yes No

- Please circle skin type: I Always burn, never tan; II Always burn, but sometimes tan; III Sometimes burn, but sometimes tan; IV Never burn, always tan

Please CHECK any skin problems you HAVE or have HAD:

- Eczema, Psoriasis, Cold sores, Frost bite, Warts, Growth removed, Skin cancer/melanoma, Other:

Have your brothers, sisters or parents had any of the following? Please CHECK:

- Asthma, hay fever, sinus problems, hives, Frostbite, Eczema, Warts, Psoriasis, Skin cancer/melanoma, Severe acne, Other:

Do you smoke? Yes No

Do you drink alcohol? Yes No

Patient or Guardian Signature: _____

For office use: Reviewed with the patient. By _____ and/or _____