Today's Date _____/_____/______

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last First Middle

□ Mr □ Mrs □ Miss □ Ms

Marital Status (circle) Single/ Married / Divorced /Sep/ Widow

Is this your legal name? □ YES □ NO

If not, what is your legal name?

Birthdate / /

Age

Sex □ M □ F □ T

Street or Mailing Address (circle one) City State Zip Code

Home Phone Number ( )

Cell Phone Number ( )

E-Mail Address

Social Security - -

Occupation

Employer

Employer Phone Number

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military

Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other __________

Pharmacy:

Do you have a living will? □ YES □ NO

Referred By (Please check one box)

□ Dr. _____________ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other ________

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient

Name

Address

Home Phone Number ( )

Birth Date / /

E-Mail Address

Occupation

Employer

Employer Address

Employer Phone Number ( )

INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)

□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE __________________________

Does the patient have healthcare coverage? □ YES □ NO

Insurance Name

Name of Insured	Social Security Number	Birth Date	Effective Date	Group ID	Subscriber ID (Policy Number)
	- -	/ /	/ /		

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other ___________________

Name of Secondary Insurance	Name of Insured	Date of Birth	Group ID	Subscriber ID (Policy Number)
		/ /		

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other ___________________

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number	Other Phone Number
		( )	( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

___________________________________ ___________________________

Patient/ Guardian Signature Date

History and Intake Form

Patient Name: ___________________________ Date: ______________

Ht: ______________ Wt: ___________________

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
GERD

Coronary Artery Disease
Depression
Diabetes
Renal Disease
High Cholesterol
Hearing Loss
Hepatitis A, B or C
High Blood pressure
HIV/AIDS

Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

Other ____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement Location:____________

Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Surgery
Liver Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Prostatectomy (Prostate Removed)
Spleenectomy (Spleen Removed)
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other ____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Cold Sores

Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Genital Herpes

Precancerous (Atypical) Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

List dates and locations of skin cancers: ____
Anything else we should know about? ____

Do you wear Sunscreen? Yes No
If yes, what SPF? _________
Do you tan in a tanning salon? Yes No

Medications: (Please enter all current medications and dosages)
____
____
____

Allergies: (Please enter all allergies)
____
____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently smoke
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Other____

Family History (Only first degree relatives: parents, siblings, children)
____

Review of Systems: Are you currently experiencing any of the following?
Please circle yes or no for the following:
Scarring problems: Yes No
Bleeding/bruising problems: Yes No
Healing problems: Yes No

ALERTS: (please circle all that apply)
Latex allergy
Allergy to adhesive/tape
Allergy to lidocaine local anesthetic
Rapid heartbeat with epinephrine
Allergy to topical antibiotics (Polysporin/Neosporin)
Artificial heart valve
Artificial joint replacement
Blood thinners
MRSA
Pacemaker/ Defibrillator
Require antibiotics prior to a surgical procedure

Females: Are you pregnant or currently trying to get pregnant? Y/N. Breast-feeding? Y/N

Immunizations:
Influenza vaccine date: _________________________________
Pneumococcal pneumonia date: _________________________________

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit in full becomes your responsibility.
4. It is the policy of this office that the adult presenting a child/minor for treatment is responsible for payment.
5. Returned checks will be subject to a returned check fee of $25.00. A fee may be charged for missed appointments.
6. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.
7. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
8. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

____ ____________________

Signature of patient, legal representative for health care services Date

If other than patient:

______________________________ ____

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent

Renewal Dermatology and Laser, APMC
10870 Brockway Rd
Truckee, CA 96161
Tel 530-550-0440 Fax 530-582-8853
www.renewalderm.com

Cancellation Policy

Renewal Dermatology and Laser, APMC, charges a cancellation fee for ALL missed appointments. If you are unable to keep your appointment, please call the office as soon as possible, so that we may help another patient in your place. If you are calling after hours, you may leave us a message on our voice mail system to cancel or reschedule your appointment.

Missed appointments (including those cancelled within 24 hours of the scheduled appointment time) will be charged a $25 missed appointment fee.

Missed extended appointments (over 15 minutes) including, but not limited to, treatments such as Levulan Photodynamic Therapy, excisions, laser and filler may be charged a $50 missed appointment fee.

Your appointment time is reserved exclusively for you. Please be considerate of others. If you miss your appointment or cancel at the last minute, we are unable to care for another patient in your place.

If you are late for your appointment, we may not be able to accommodate you and we may need to reschedule your visit. If you think you will be late for your appointment, please call us as soon as possible, so that we may advise you whether your late arrival can be accommodated or rescheduling is needed.

We make a sincere attempt to see you on time for your appointment. However, unexpected emergencies can occur and sometimes cause unavoidable delays in our schedule. If this happens, we will notify you and give you a choice of staying or rescheduling without penalty.

Your signature below signifies that you understand our Cancellation Policy and your responsibility regarding charges incurred as a result of failing to comply.

Patient/ Legal Guardian Signature: ____

Patient/Legal Guardian Print Name: ____

Date: ____________________

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

With my consent, Renewal Dermatology & Laser may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Renewal Dermatology & Laser Notice of Privacy Practices for a more complete description of such uses and disclosures. The practice provides this form to comply with the Health Information Portability and Accountability Act (HIPAA) of 1996.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Renewal Dermatology & Laser reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Renewal Dermatology & Laser Privacy Officer.

With my consent, Renewal Dermatology & Laser may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and others.

With my consent, Renewal Dermatology & Laser may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements.

With my consent, Renewal Dermatology & Laser may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements. I have the right to request that Renewal Dermatology & Laser restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Renewal Dermatology & Laser's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If l do not sign this consent, Renewal Dermatology & Laser may decline to provide treatment to me.

COMMUNICATION PREFERENCE

Phone number to call with medical information: ________________________ **Cell Home Work**

May we leave a message with personal medical information on this number? **Yes / No**

Do you give our office permission to discuss medical information with family members? **Yes / No**

If yes, please provide their names below:

Name: ___________________________________ Relationship: __________________________

Name: ___________________________________ Relationship: __________________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PATIENT'S NAME (PLEASE PRINT)