

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Patient Name Last			First	Middle	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow	
					<input type="checkbox"/> Miss	<input type="checkbox"/> Ms		
Is this your legal name? <input type="checkbox"/> YES <input type="checkbox"/> NO		If not, what is your legal name?			Birthdate / /		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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			
<b>Employment Status:</b> <input type="checkbox"/> 1 – Full-Time <input type="checkbox"/> 2 – Part-Time <input type="checkbox"/> 3 – Not Employed <input type="checkbox"/> 4 – Self-Employed <input type="checkbox"/> 5 – Retired <input type="checkbox"/> 6 – Active Military <b>Student Status:</b> <input type="checkbox"/> F – Full-Time Student <input type="checkbox"/> P – Part-Time Student <input type="checkbox"/> N – Not a Student								
<b>Race:</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Declined <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined <b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other _____								

<b>Pharmacy:</b>	Do you have a living will? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Referred By ( Please check one box)  
 Dr. \_\_\_\_\_  Insurance  Hospital  Family  Friend  Yellow Pages  Other \_\_\_\_\_

Other Family Members Seen Here

PCP Name	Phone #
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## RESPONSIBLE PARTY INFORMATION

Responsible Party: <input type="checkbox"/> Another Patient <input type="checkbox"/> Guarantor <input type="checkbox"/> Self <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance		Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

## EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )
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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: \_\_\_\_\_  
 Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Date: \_\_\_\_\_

**Past Medical History:** (please circle all that apply)

- |                             |                         |                     |
|-----------------------------|-------------------------|---------------------|
| Anxiety                     | Coronary Artery Disease | Hyperthyroidism     |
| Arthritis                   | Depression              | Hypothyroidism      |
| Asthma                      | Diabetes                | Leukemia            |
| Atrial fibrillation         | Renal Disease           | Lung Cancer         |
| Bone Marrow Transplantation | High Cholesterol        | Lymphoma            |
| Breast Cancer               | Hearing Loss            | Prostate Cancer     |
| Colon Cancer                | Hepatitis A, B or C     | Radiation Treatment |
| COPD                        | High Blood pressure     | Seizures            |
| GERD                        | HIV/AIDS                | Stroke              |
|                             |                         | NONE                |

Other \_\_\_\_\_

**Past Surgical History:** (please circle all that apply)

- |  |  |
|--|--|
| Appendix Removed                                 | Kidney Biopsy                              |
| Bladder Removed                                  | Kidney Stone Removal                       |
| Mastectomy (Right, Left, Bilateral)              | Kidney Transplant                          |
| Lumpectomy (Right, Left, Bilateral)              | Kidney Removed (Right, Left)               |
| Breast Biopsy (Right, Left, Bilateral)           | Liver Surgery                              |
| Breast Reduction                                 | Liver Transplant                           |
| Breast Implants                                  | Ovaries Removed: Endometriosis             |
| Colectomy: Colon Cancer Resection                | Ovaries Removed: Cyst                      |
| Colectomy: Diverticulitis                        | Ovaries Removed: Ovarian Cancer            |
| Colectomy: IBD                                   | Prostate Removed: Prostate Cancer          |
| Gallbladder Removed                              | Prostate Biopsy                            |
| Coronary Artery Bypass                           | Prostatectomy (Prostate Removed)           |
| Mechanical Valve Replacement                     | Splenectomy (Spleen Removed)               |
| Biological Valve Replacement                     | Testicles Removed (Right, Left, Bilateral) |
| Heart Transplant                                 | Hysterectomy: Fibroids                     |
| Joint Replacement, Hip (Right, Left, Bilateral)  | Hysterectomy: Uterine Cancer               |
| Joint Replacement, Knee (Right, Left, Bilateral) | NONE                                       |
| Joint Replacement Location: _____                |  |
| Other _____                                      |  |

**Skin Disease History:** (please circle all that apply)

- |                        |                        |                               |
|------------------------|------------------------|-------------------------------|
| Acne                   | Eczema                 | Precancerous (Atypical) Moles |
| Actinic Keratoses      | Flaking or Itchy Scalp | Psoriasis                     |
| Asthma                 | Hay Fever/Allergies    | Squamous Cell Skin Cancer     |
| Basal Cell Skin Cancer | Melanoma               | NONE                          |
| Blistering Sunburns    | Genital Herpes         |                               |
| Cold Sores             |                        |                               |

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)

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**Allergies:** (Please enter all allergies)

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**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)

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**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](http://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 I do not sign this consent, Renewal Dermatology & Laser may decline to provide treatment to me.

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SIGNATURE OF PATIENT OR LEGAL GUARDIAN

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DATE

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PATIENT'S NAME (PLEASE PRINT)



**RELEASE OF MEDICAL INFORMATION/ CONTACT PERMISSION**

In the event that we need to contact you (patient) regarding medical information about an appointment, lab/biopsy result, medication, or any other reason, it is permissible to release your information:

Leave a message on an answering machine/voicemail?       YES       NO

Speak with spouse / significant other?       YES       NO

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Speak with other family members?       YES       NO

Name(s): \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

- OR -

I DO NOT authorize my medical information to be released to anyone \_\_\_\_\_ (Initial)

\_\_\_\_\_  
Patient (or responsible party) Signature

\_\_\_\_\_  
Patient PRINTED Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Date