PLEASE COMPLETE BOTH SIDES

DATE:_____

PLEASE PRINT CLEARLY

PATIENT INFORMATION			PATIENT REGISTRATION #:	
LAST NAME	FIRST	MI	HOME PHONE ( )	MALE ☐ FEMALE ☐
AGE / DATE OF BIRTH	MARITAL STATUS: ☐ MAR ☐ SING ☐ WID. ☐ SEP. ☐ DIV.		SOCIAL SECURITY #:	REFERRING PHYSICIAN
PERMANENT ADDRESS STREET	CITY	STATE ZIP CODE		FAMILY PHYSICIAN
TEMPORARY ADDRESS STREET	CITY	STATE ZIP CODE		PHONE #: ( )
PATIENT'S EMPLOYER	ADDRESS		OCCUPATION	PHONE #: ( )
NAME OF SPOUSE	EMPLOYED BY		OCCUPATION	WORK PHONE ( )

PERSON RESPONSIBLE FOR PAYMENT

LAST NAME FIRST MIDDLE	SOCIAL SECURITY #:	REL. TO PATIENT
ADDRESS STREET CITY STATE ZIP CODE		PHONE #: ( )
EMPLOYED BY ADDRESS		WORK PHONE ( )

INSURANCE INFORMATION

☐ SELF PAY
☐ MEDICARE
☐ GROUP INS.
☐ MEDICAID
☐ BLUE SHIELD
☐ CHAMPUS
☐ OTHER

PRIMARY			SECONDARY		
NAME OF INSURANCE COMPANY			NAME OF INSURANCE COMPANY		
ADDRESS OF INSURANCE COMPANY			ADDRESS OF INSURANCE COMPANY		
COMPLETE NUMBER AS STATED ON CARD			COMPLETE NUMBER AS STATED ON CARD		
POLICY HOLDER NAME	D.O.B.	REL/PAT	POLICY HOLDER NAME	D.O.B.	REL/PAT

NOTE: Any claim of insurance or group agency coverage must be confirmed by an Identification card or letter of authorization from the company or agency at the time of visit

I certify that the information given by me in applying for payment under my insurance contract (including Title XVIII of the Social Security Act) is correct. I authorize you to release to my insurance carrier, employer and referring physician any information needed including the diagnosis and records of any treatment or examination to me to process the claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to my health insurance carrier (including Medicare) for payment to me.

LIFETIME SIGNATURE AUTHORIZATION

This authorization and assignment is to be continued, remaining in force until revoked in writing by the undersigned for services beginning.

DATE:_____ SIGNATURE:_____ WITNESS:_____

(IF MINOR, PARENT OR GUARDIAN)

OVER PLEASE

MEDICAL/SURGICAL HISTORY

Date: _____ Age: _____

1. Please state the nature of your current problem: _____

_____

2. How long have you had this problem? _____

3. What area of the body does it mainly affect? _____

4. How severe is the condition that affects you? (circle please) mild moderate severe

5. Has anything that you have used helped or worsened the condition? If so, please state

_____

6. Do you have any problems with your digestive system? YES or NO If yes, list please

_____

7. Do you have any problems with you respiratory system? YES or NO If yes, list please

_____

8. Do you have any artificial joints, hip, knee or shoulder replacements, heart valves or other prosthetic devices in your body from surgeries? (such as pins; plates, screws) YES or NO If yes, list please

_____

9. Do you have a pacemaker or defibrillator or mitral valve prolapse? YES or NO If yes, list please

_____

10. Please list your current medications and any you have taken within the last month. Please include all over-the-counter meds. and vitamins/herbs: _____

_____

11. Do any members of your family have hayfever, asthma, or eczema? YES or NO

12. Are you allergic to Penicillin, sulfa drugs, lidocaine, neomycin, tape adhesive, iodine or any medications?

_____

13. Please list all surgeries you have had. Include the date please: _____

_____

14. Have you ever been treated for skin cancer? YES or NO If so, what kind/where _____
15. Has anyone in your family been treated for skin cancer? If so, what kind? _____
16. Do you have any bleeding or clotting disorders? YES or NO
17. If you smoke tobacco or drink more than two drinks of alcohol/day, please state how much. _____

_____

18. Are you HIV or Hepatitis ____ Positive ? YES or NO
19. Do you have any medical illness? (High Blood Pressure, Diabetes, etc.) If yes, please list _____

_____

20. FEMALES: IS THERE ANY CHANCE YOU ARE PREGNANT OR NURSING? YES Or NO
IF SO, PLEASE VERBALLY ALERT THE DOCTOR.

PATIENT OR GUARDIAN SIGNATURE: _____

Melbourne Dermatology Center

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Melbourne Dermatology Center's Notice of Privacy Practices.

Name _____
Signature _____
Date _____

This acknowledgement page should be retained in the patient's record. If acknowledgement could not be obtained from patient, the reasons must be documented below.

_____
_____
_____
_____

Protected Health Information Release Form

In compliance with **HIPAA** regulations, and in order to facilitate requests for your protected health information, please complete the lower portion of this form.

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. Melbourne Dermatology Center is permitted to share with them test results and information disclosed during my office visits. For copies of medical records, I understand that I will need to sign a separate authorization. Please list below, those individuals that you wish to receive your protected health information:

_____ _____
Full Name Relationship

_____ _____
Full Name Relationship

In addition to those individuals listed above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

___ Leaving messages on answering machine at _____.
___ Leaving messages on my work voicemail at _____.
___ Leaving messages on my pager at _____.
___ Leaving messages on my cell phone at _____.
___ Other forms of communication _____.

I understand that I will update Melbourne Dermatology Center with any changes in the above listed contact numbers.
I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____
Patient Name Date

_____
Patient Signature

_____ _____
Witness Name Date