**DERMATOLOGIC CENTER FOR EXCELLENCE**

**ANTHONY S. DEE, MD DANIELLE JOHNSTON, RPA-C**

**PATIENT REGISTRATION FORM** Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide contact information and *indicate your preferred contact number*:

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message? Y N May we text you to confirm appointments? Y N

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married Divorced Widowed

Ethnic Group Race

Hispanic or Latino White

Not Hispanic or Latino African American

Decline American Indian or Alaska Native

Asian

Native Hawaiian or Pacific Islander

Other Race

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor patient’s parent/guardian name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is *financially* responsible for patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address, if different from patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE INFORMATION**

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize Dr. Anthony Dee to furnish information to insurance carriers concerning my illness and treatments, and I do hereby assign to the physician all payment for medical service rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.**

**Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_

**DERMATOLOGIC CENTER FOR EXCELLENCE**

**ANTHONY S. DEE, MD DANIELLE JOHNSTON, RPA-C**

**PATIENT INTAKE FORM**

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

Chief complaint today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select any of the following medical conditions that you currently have:

Anxiety Coronary Artery Disease Hyperthyroidism Arthritis Depression Hypothyroidism Asthma Diabetes Leukemia Atrial Fibrillation End Stage Renal Disease Lung Cancer (irregular heartbeat) GERD Lymphoma Bone Marrow Hearing Loss Prostate Cancer Transplantation Hepatitis Radiation Treatment BPH Hypertension/High Blood Seizures Breast Cancer Pressure Stroke Colon Cancer Hypercholesterolemia/High COPD Cholesterol None

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any past surgical procedures and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do any of the above procedures require that you take an antibiotic before the dentist (premedicate)? Yes No**

Have you had any of the following skin conditions?

Acne Eczema Precancerous Moles

Actinic Keratoses Flaking or Itchy Scalp Psoriasis Asthma Hay Fever/Allergies Squamous Cell Carcinoma Basal Cell Carcinoma Melanoma\*\* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blistering Sunburns When? \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dry Skin Poison Ivy None

Do you wear sunscreen? Yes No

If yes, what SPF? \_\_\_\_\_\_\_\_\_\_\_\_

Do you tan in a tanning salon? Yes No

Do you have an *immediate* family history of melanoma? Yes No

If yes, which relative(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Do you smoke?

None Never smoked

Less than 1 drink per day Former smoker

1-2 drinks per day Current every day smoker

3 or more drinks per day Current some day smoker

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

**Please list any medications you are currently taking, including over-the-counter:**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | Frequency | Date Started |
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Are you allergic to any medications? Y N If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For new patients only***: Are you experiencing difficulty ***today*** with any of the following:

Problems with bleeding Unintentional Weight Loss Headaches

Problems with healing Thyroid Problems Seizures

Problems with scarring Sore Throat Cough

(hypertrophic/keloid) Blurry Vision Shortness of Rash Abdominal Pain breath

Immunosuppression Bloody Stool Wheezing

Anxiety Chest Pain Joint Aches Depression Fever or Chills Muscle Aches

Muscle Weakness Night Sweats

**Alerts**: Do you have any of the following?

Allergy to adhesive Defibrillator

Allergy to lidocaine MRSA

Allergy to topical antibiotic ointments Pacemaker

Artificial heart valve Premedication prior to procedures

Artificial joints within past two years Rapid heartbeat with epinephrine

Blood thinners Pregnancy or planning a pregnancy

**HIPAA**

**PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations

The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice

The practice reserves the right to change the Notice of Privacy Practices

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this Consent.

Do we have your permission to:

Leave a message on your answering machine at home? \_\_\_\_\_ yes \_\_\_\_\_ no

Leave a message at your place of employment? \_\_\_\_\_ yes \_\_\_\_\_ no

Obtain prescription history? ­\_\_\_\_\_ yes \_\_\_\_\_ no

Discuss your medical condition with any member of your household? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent was signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed Name-Patient or Representative) (Relationship)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature) (date)

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Signature) (date)

**ANTHONY DEE, M.D., PLLC**

**DANIELLE JOHNSTON, RPA-C**

**Dermatologic Center for Excellence**

9276 Main Street, Suite 1A

P.O. Box 554

Clarence, New York 14031-0554

Phone: (716) 759-7759

Fax: (716) 759-1759

**FINANCIAL POLICY**

Our staff is committed to providing you with the best medical care possible. Our office participates in a variety of insurance plans. If you have an insurance plan in which we do not participate, you will be **required** to sign an out-of-network waiver and our office will be happy to assist you in filing the insurance claim upon request. However, payment in full is expected at the time of service and your insurance company will reimburse you accordingly.

If you have questions regarding your insurance, we will try to help. However, questions relating to specific coverage issues must be directed to your insurance company’s member services department. Their telephone number is usually on the back of your card.

The following apply to every visit.

* Bring your insurance card.
* **Be prepared to pay your co-payment amount.** We accept cash, check and credit card payments. The fee for returned checks is $25. Check Velocity is used for returned checks.
* For medical care not covered by your insurance, payment in full is due at the time of the visit.

*Co-payments and deductibles****:* Please be prepared to pay your co-payment amount at each visit.** We will not waive or discount co-payments or deductible payments that are **required** by your health insurance carrier.

*Referrals:* Many insurance plans require a referral from your primary care physician to be seen by a specialist. To avoid delays, please bring any required referral for treatment at the time of your visit. If you do not have a required referral, your visit may be rescheduled or you may be financially responsible.

*Delinquent accounts:* Please remember that it is your responsibility to pay your bill in full when you are billed. We realize that there may be extraordinary circumstances which make it impossible to do so. If you are experiencing such difficulties, we may be able to make special arrangements in your case, but only if you call the office for assistance. **All delinquent accounts over 30 days will be subject to an additional interest charge of 1 1/2% per month. A charge of the current billing rate will be assessed for missed or cancelled appointments without 24 hour advance notice. Missed or cancelled surgical appointments less than 24 hours in advance will be assessed a $100.00 fee.**

I certify that I have read and understand this financial policy.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_