MIDWEST DERMATOLOGY

PATIENT REGISTRATION FORM

Today's Date_____

Last Name _____ **First** _____ **M.I.**_____

Date of Birth _____/_____/_____ **Social Security Number** _____/_____/_____ **Marital Status**_____ **Sex** _____

Street Address _____ **Apt #** _____ **City**_____

State _____ **Zip** _____ **Home Phone** (_____) _____ **Cell Phone** (_____) _____

Employer_____ **Occupation**_____ **Work** (____) _____

Employer Address _____ **City**_____ **State**_____ **Zip**_____

Name of Spouse_____ **Employer** _____ **Work** (____) _____

Person to notify in case of emergency _____ **Phone** (____) _____

Referring Doctor/Practice _____ **Phone** (____) _____

May we leave a message on your home answering machine/cell phone? ___ Yes ___ No
May we leave a message for you at work to call us? ___ Yes ___ No
May we discuss your medical condition with another person? ___ Yes ___ No

If yes, with whom _____ **Relationship** _____ **Phone** (___) _____

Permission to email/fax any correspondence to you at your request i.e. itemized billing: ___ Yes ___ No

Would you like to be informed about special pricing, promotions and/or services via email? ___ Yes ___ No

E-Mail Address: _____

How did you hear about our practice? _____

If patient is a minor please enter responsible party information. *(Note we do not bill absent parents. The adult presenting the minor for care is responsible party.)*

Last Name _____ **First** _____ **M.I.**_____

Relationship to patient _____ **Date of Birth** _____/____/_____ **Social Security Number**_____/____/_____

Street Address_____ **City**_____ **State** _____ **Zip**_____

Primary Insurance:

Name of Insurance _____
Name of Policy Holder _____
Policy Holder Date of Birth _____
Policy Holder SS# _____
Policy Holder Employer _____
Policy Holder Work Phone_____
Relationship to Patient_____

Secondary Insurance:

Name of Insurance _____
Name of Policy Holder _____
Policy Holder Date of Birth _____
Policy Holder SS# _____
Policy Holder Employer _____
Policy Holder Work Phone_____
Relationship to Patient_____

MIDWEST DERMATOLOGY
Medical History Form

Name: _____ **Date:** _____/_____/_____
DOB: _____/_____/_____ **Sex:** M / F **Height:** _____ **Weight:** _____ **Are you Pregnant:** Y / N
Reason for today's visit: _____ **Referred By:** _____
Symptoms of today's problem: _____
Skin areas / location involved: _____
How long / duration has the problem been present: _____
Any previous treatment? Y / N **When:** _____ **Type Trmnt:** _____
Was a biopsy done? Y / N **Preformed by/where?** _____

CHECK ALL THAT APPLY TO TODAY'S PROBLEM

QUALITY (change in)
___ size
___ color
___ elevation
___ hardness
___ other _____
___ none

MODIFYING FACTORS (history of)
___ X-ray treatments (no routine dental or chest x-rays)
___ UV light treatments
___ arsenic exp / treatments
___ chronic scar
___ immunosuppression
___ none

ASSOCIATED SYMPTOMS
___ bleeding
___ tingling
___ pain
___ ulceration
___ infection
___ itching
___ other _____ or ___ none

SEVERITY
___ no symptoms
___ occasional symptoms
___ constant symptoms

SYSTEM REVIEW: Check all that apply regarding your health and add any other important problems or concerns

MEDICATIONS: _____

LIST ALLERGIES: _____

SKIN
___ abnormal scarring
___ poor healing
___ other:_____ ___

PSYCHIATRIC
___ normal
___ depression
___ anxiety attacks
___other:_____

CARDIOVASCULAR
___ normal
___ angina
___ artificial heart valve
___pacemaker
___hypertension
___ heart attack, when?_____

HEMATOLOGIC / LYMPHATIC
___ normal
___ anemia
___ bleeding problems
___ enlarged lymph nodes

RESPIRATORY
___ normal
___ asthma
___ emphysema
___ other :_____

GASTRONINTESTINAL
___ normal
___ stomach ulcer
___ colitis
___ liver damage
___ other: _____

CONSTITUTIONAL SYSTEMS
___ none
___ weight loss
___ fever
___ other:_____

NEUROLOGICAL
___ normal
___ stroke
___ seizures
___ other :_____

ENDOCRINE
___ normal
___ diabetes
___ thyroid
___ kidney disease
___ excessive sweating under arms
___ other:_____

EYES / EARS / NOSE / THROAT
___ normal
___ glaucoma
___ hearing aid
___ plastic surgery

MUSCULOSKELETAL
___ normal
___ artificial joint
___ arthritis
___ other:_____

INFECTIONS
___ normal
___ hepatitis
___ HIV / AIDS
___ tuberculosis-TB
__other:_____

Other Health Problems: _____
Previous Skin Cancer: Y / N *If yes, list dates & locations:_____
Family History of Skin Cancer: _____
List any major illnesses or hospitalizations: _____

SOCIAL HISTORY: *Occupation: _____ *Marital status: ___Single ___Married ___Divorced ___Widowed
*Previous sunlight exposure or sunburns: ___mild ___moderate ___extensive *Do you use tanning beds? Y or N
*Do you wear: ___dentures ___glasses ___contact lenses *Do you smoke: Y / N / Former *How often?: _____
*Do you drink alcohol: ___no ___social / occasional drinking only *Alcohol or drug problems / addictions: Y / N

SIGNATURE CONFIRMING TODAY'S VISIT: _____ **DATE:** _____

PATIENT FINANCIAL POLICY

We would like to thank you for choosing Midwest Dermatology as your medical provider. To keep you informed of our current financial policies we ask that you read and sign our financial acknowledgement prior to any treatment.

Credit Card Policy: Midwest Dermatology has recently implemented a new billing process that will enable patients to save a charge card on file, which will be used to pay for any portion of a visit that is not covered by insurance. This process offers benefits to our patients, insurers and the environment. You will not have to worry about writing checks, mailing payments or paying on time. The system will process the payment for you automatically. If you provide an email address, you will receive a notification and receipt via email when your credit card has been charged, Because you will not receive an invoice or receipt by mail, this environmentally friendly process reduces the amount of mail you receive and paper used. Your credit card information is encrypted, stored in a specially secured facility and is only accessible by the credit card processors. The amount you will be charged is strictly limited to the contractually obligated amount your insurance requires you to pay, such as copayments, co-insurance, deductible and non-covered services.

Canceled Appointments: In the event you are unable to keep your scheduled appointment, you are required to call our office within 24 hours to reschedule for another time. This will allow time to use your slot for another patient. Due to the shortage of dermatologist in the Kansas City area a large number of patients need our care, Midwest Dermatology works very hard to meet the needs of our patients. It has never been our policy to double book appointments. Your appointment time is especially reserved for you. Because of this we ask that you notify our office 24 hours in advance if you cannot keep an appointment so that we may utilize this time for another patient. We will charge patients $50.00 for all medical appointment, $75.00 for all cosmetic consultations and $250.00 for all missed appointments involving a scheduled surgery, biopsy or other procedure, that are missed without 24 hour notification. We greatly regret the need for this policy, however we feel it is very important to see all patients as soon as possible to give them the highest quality care.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. Please be aware that any costs not covered by insurance are your responsibility. It is the patient's responsibility to determine coverage. You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a notice from your insurance company indicating they paid. Any remaining balance will be placed on your credit card. You will be notified of the amount if you have provided us with an email address. You are also responsible for collection costs, attorney fees, court costs and 18% annual interest on any unpaid balance. If your account is placed in collections, a collection fee will be added to the balance owed.

HMO or POS: If your insurance carrier requires that you obtain a referral from you Primary Care Physician (PCP), please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

No Insurance: Payment will be due at time of service.

If you do not have one of the plans in which our practice has a contract, the total cost of your visit is required at the time of service. If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you. For your convenience, this office accepts Master Card, Visa, Discover, American Express, and CareCredit in addition to cash and checks.

I certify that I have read the financial policy of Midwest Dermatology and agree to abide by the policy.

Patient Signature/Legal Representative: _____ Date: _____

ACKNOWLEDGE OF HIPAA PRIVACY ACT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, to obtain payment from third-party and to conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Midwest Dermatology's Privacy Practices available in the waiting room or upon my request containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound by such restrictions.

Patient Signature/Legal Representative: _____Date: _____

Witness: _____Date: _____

Thank you for choosing Midwest Dermatology for your healthcare needs.