PATIENT REGISTRATION

(Please Print)

Date:_______________ Acct:_______________

Name____ Home Phone_________________________________
Last, First, (MI)

Street____ Work Phone_____________Cell Phone______________

City___________________State______Zip____________ E-Mail Address________________________________

Patient SSN______________________________________ Date of Birth_____________________

Occupation_______________________________________ Spouse's/Parent's Name________________________

Employer____ Spouse's/Parent's Employer_____________________

Emergency Contact: Name_______________________ Phone #____

Personal Physician__________________Address___________________________ Phone#_____________________

Preferred Pharmacy____ Phone#_____________________

Referred by whom?(Name & Phone #)____

Language spoken________________________Gender Identification:____________________________________

PAST/FAMILY/SOCIAL HISTORY

Drug/ Food Allergies____
Current Medications____
Chronic Illnesses____
Past Surgeries____
Do you have any artificial joints? Yes / No Mitral valve prolapse or artificial heart valve? Yes / No
Do you have a pacemaker/defibrillator? Yes/ No
Alcohol Intake_____________________________________ Illicit Drug Use________________________________
Smoking Status/History____
Family Diseases____
Family/Personal History of Skin Cancer____

REVIEW OF SYSTEMS

Do you have any recent problems with the following? If yes, please describe in this space.

Fevers/Chills/Weight loss?	Yes/No
Sore eyes/Dry eyes?	Yes/No
Sores in mouth or nose?	Yes/No
Chest Pain/Leg swelling?	Yes/No
Nausea/Diarrhea?	Yes/No
Burning urination/Frequent urination?	Yes/No
Muscle or joint pain?	Yes/No
Numbness of feet/Dizziness?	Yes/No
Depressed/Anxious Mood?	Yes/No
Fatigue/Cold Intolerance?	Yes/No
Swollen lymph glands?	Yes/No

PLEASE COMPLETE THIS FORM FRONT AND BACK(TURN OVER TO CONTINUE)

BILLING INFORMATION

Payment of insurance co-pay/or for any cosmetic services is expected the day services are rendered. We accept MC/VISA/Discover/American Express/Check/Cash.

RESPONSIBLE PARTY: ____________________Relationship_____________Date of Birth_________

Phone #_________________________________SSN_________________

Street Address_____________________________City_________________State_______Zip______

PRIMARY INSURANCE: _________________________Amount of Deductible/co-pay_____________
Policyholder's Information:

Name___________________________________Relationship___________Date of Birth__________

Member ID#_____________________________Phone #_______________

Street Address_____________________________City__________________State______Zip______

SECONDARY INSURANCE: ______________________
Policyholder's Information:

Name___________________________________Relationship____________Date of Birth_________

Member ID#_____________________________Phone #__________________

Street Address________________ ___________City_________________State _______Zip_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Distinctive Dermatology, LTD, for services rendered by the physician in person or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

ALL INSURANCE AND MEDICARE

I hereby authorize Distinctive Dermatology to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

NO-SHOW APPOINTMENT POLICY

I hereby authorize Distinctive Dermatology to charge my account **$50.00 NO SHOW FEE** for Established visits **$100.00 NO SHOW FEE** for Scheduled Surgeries and Cosmetics appointments if I do not show for a scheduled appointment without calling and cancelling/rescheduling the appointment within 24 hours of the appointment date.

PROTECTED HEALTH INFORMATION

I hereby authorize Distinctive Dermatology to release or obtain from other physicians and medical facilities whatever records are necessary for my continued care.

SIGNATURE:
PATIENT, PARENT OR LEGAL GUARDIAN______________________________**DATE**_________

I hereby authorize Distinctive Dermatology to release any medical information for the treatment of my care.
Person(s) to whom information may be disclosed:

____ ____________________________________

Name of Person/relationship Name of Person/relationship

SIGNATURE:
PATIENT, PARENT OR LEGAL
GUARDIAN____**DATE**____________________