



PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Name (as it appears on Driver's License or Photo ID): First Middle Last			Patient Date of Birth (MM/DD/YYYY):
			Social Security Number:
Mailing Address (Street, City, State, ZIP):			Patient Gender (circle): Male Female
			Marital Status:
Email Address:			Occupation:
Home Phone Number:			Employer:
Cell Phone Number:			Employer Phone Number:
Referred to Clinic By (Please circle): Dr. _____ Family / Friend Insurance Company Web Search Print Ad Other: _____			
Primary Care Physician (PCP) Name:			PCP Phone Number (if known):

RESPONSIBLE PARTY INFORMATION (Spouse / Parent / Legal Guardian)

Guarantor on Account (eg, responsible parent if patient is a minor):	Guarantor Phone Number:	Guarantor Relationship to Patient:
Guarantor Date of Birth (MM/DD/YYYY):	Guarantor Mailing Address (Street, City, State, ZIP):	

INSURANCE INFORMATION

Primary Insurance Company:	Policy/ID Number:	Group Number:
Policyholder's Name:	Policyholder's Date of Birth:	Relationship to Patient:
Specialist Copay Amount: \$ _____		
Secondary Insurance Company:	Policy/ID Number:	Group Number:
Policyholder's Name:	Policyholder's Date of Birth:	Relationship to Patient:

EMERGENCY CONTACT (Please list anyone you authorize to receive protected health information)

Name:	Relationship to Patient:	Phone Number:
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LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Epiphany Dermatology and its related companies. I understand that I am financially responsible for any balance. I also authorize Epiphany Dermatology, its related companies, or insurance company to release medical information required to process claims.

Notice of Privacy Practices: I have read or been offered a copy of Epiphany Dermatology's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.

Consent for Communication: I understand Epiphany Dermatology will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.

Payment Policy: Payment is due at time of service, including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Epiphany Dermatology and its related companies.

Legal: This form applies to Epiphany Dermatology and its related companies including Epiphany Dermatology PA, Brownwood Dermatology PLLC, Epiphany Dermatology of New Mexico, LLC, Epiphany Dermatology of Oklahoma, LLC, Academy Dermatologists Group, LLC, and Epiphany Dermatology of Missouri, LLC.

SIGNATURE

Patient / Guardian Signature:	Date:
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Medical History and Intake Form



Patient Name: _____

Date of Birth (MM/DD/YYYY): _____

Reason for visit, location of problem, duration of problem: _____

Past Medical History: (Check all that apply. If NONE, please check NONE)

- | | | |
|-------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------|
| <input type="radio"/> Allergies (Seasonal) | <input type="radio"/> Heart Valve Replacement | <input type="radio"/> Lumpectomy |
| <input type="radio"/> Asthma | <input type="radio"/> High Blood Pressure | <input type="radio"/> Lupus / Rheumatoid Arthritis |
| <input type="radio"/> Bleeding Disorder (or bleeding issue) | <input type="radio"/> High Cholesterol | <input type="radio"/> Mastectomy |
| <input type="radio"/> Cancer: _____ | <input type="radio"/> HIV/AIDS | <input type="radio"/> Organ Transplant |
| <input type="radio"/> Coronary Artery Bypass | <input type="radio"/> Joint Replacement | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Depression | <input type="radio"/> Kidney Transplant | <input type="radio"/> NONE |
| <input type="radio"/> Diabetes | <input type="radio"/> Liver Disease | |
| <input type="radio"/> Fever Blister | | |

Do you have a history of Skin Cancer or Skin Disorders? (Examples: acne, actinic keratosis, basal cell, melanoma, psoriasis, squamous cell) Yes _____ No _____ If yes, please indicate condition or disorder: _____

Family History of Skin Cancer including Melanoma? Yes _____ No _____

If yes, whom: _____

Medications: (Enter all current medications including non-prescription and birth control; if none mark N/A)

Allergies: (Please enter all allergies including allergy to medications; if none mark N/A)

Social History:

Do you smoke? Yes ___ No ___ If yes, how much? _____ Do you drink alcohol? Yes ___ No ___ If yes, how much? _____

Review of Systems: (Check all that apply)

- | | |
|------------------------------------------------------|-------------------------------------------------|
| <input type="radio"/> Problems with bleeding | <input type="radio"/> Night sweats |
| <input type="radio"/> Problems with healing | <input type="radio"/> Unintentional weight loss |
| <input type="radio"/> Problems with scarring/keloids | <input type="radio"/> Joint pain |
| <input type="radio"/> Fever or Chills | |

Alerts: (Check all that apply. If NONE, please check NONE)

- | | |
|------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="radio"/> Allergy to Adhesive | <input type="radio"/> MRSA |
| <input type="radio"/> Allergy to Lidocaine | <input type="radio"/> Pacemaker |
| <input type="radio"/> Allergy to Topical Antibiotics | <input type="radio"/> Require antibiotics prior to a surgical procedure |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Rapid heart beat with Epinephrine |
| <input type="radio"/> Artificial Joint Replacement | <input type="radio"/> Are you pregnant or currently trying to get pregnant? |
| <input type="radio"/> Blood Thinners | <input type="radio"/> Breastfeeding |
| <input type="radio"/> Defibrillator | <input type="radio"/> NONE |

Preferred Pharmacy Name: _____

Telephone (if known): _____

Address (or cross streets): _____

City: _____