EPIPHANY DERMATOLOGY

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:* ◯ *Male* ◯ *Female*
	Marital Status:
Email Address:	*Occupation:*
Home Phone Number:	*Employer:*
Cell Phone Number:	*Employer Phone Number:*
Referred to Clinic By: *Dr.* _____ ◯ *Family / Friend* ◯ *Insurance Company* ◯ *Web Search* ◯ *Print Ad* *Other:* _____	
Primary Care Physician (PCP) Name:	*PCP Phone Number (if known):*

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

Name:	*Relationship to Patient:*	*Phone Number:*

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:*

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.*

Patient Rights: *I have read or been offered a copy of Epiphany Dermatology Patient Rights.*

Patient Rights Document Received: ◯ *Received* ◯ *Declined.*

SIGNATURE

Patient / Guardian Signature:	*Date:*

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)

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

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)

- ○ Problems with bleeding
- ○ Problems with healing
- ○ Problems with scarring/keloids
- ○ Fever or Chills
- ○ Night sweats
- ○ Unintentional weight loss
- ○ Joint pain

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

- ○ Allergy to Adhesive
- ○ Allergy to Lidocaine
- ○ Allergy to Topical Antibiotics
- ○ Artificial Heart Valve
- ○ Artificial Joint Replacement
- ○ Blood Thinners
- ○ Defibrillator
- ○ MRSA
- ○ Pacemaker
- ○ Require antibiotics prior to a surgical procedure
- ○ Rapid heart beat with Epinephrine
- ○ Are you pregnant or currently trying to get pregnant?
- ○ Breastfeeding
- ○ **NONE**

Preferred Pharmacy Name: _____ **Telephone (if known):** _____

Address (or cross streets):_____ **City:** _____