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.*

Authorizations: *I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that medical treatment may include a review of medical history, discussion of reason for visit and medical photographs of the area being discussed. I authorize Epiphany Dermatology and its related companies to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Epiphany Dermatology's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Epiphany Dermatology.*

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.*

Late or Missed Appointment Policy: *We require a 24-hour cancellation notice if you are not able to keep your appointment. No-show appointments are subject to a no-show fee (including surgery and cosmetics) as missed appointments prevent other patients from seeing our providers in a timely fashion. See office "Late or Missed Appointment Policy" for pricing.*

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:** _____

EPIPHANY DERMATOLOGY

6601 Vaught Ranch Rd, Ste 200
Austin, TX 78730
Phone: (512) 628-0465
Fax: (512) 628-0468

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name (as it appears on DL/State ID): Date of Birth: [DOB]_____/_____/_____

_____

I request and authorize **Epiphany Dermatology** to release healthcare information of the patient named above to:

Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

Please send copies of the following Medical Records (check all that apply):

___ Office Consult notes ___ Pathology report(s) ___ Lab report(s)

___ Entire Medical Records

___Other:_____

I understand the following:
I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.

I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may refuse to sign this authorization

Patient/Guardian Signature: _____ Date:_____

Exp Date (One year from date of request): _____