VIVIDA DERMATOLOGY

Patient Registration Form

Please complete all the information below in print, please do not leave any questions blank. Thank You!

PATIENT INFORMATION:

Last Name: _____ First Name:_____ Date of Birth:_____ Sex:_____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Ok to Leave detailed message: YES ___ NO___

Email: _____ SSN: _____Marital Status: _____ How did you hear about us? _____

EMERGENCY CONTACT:

Name: _____Relationship: _____Cell Phone: _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____Member ID: _____ Group ID: _____

Primary Policy Holder: _____ Relationship:_____ Date of Birth:_____

SECONDARY INSURANCE INFORMATION:

Name of Insurance: _____Member ID: _____ Group ID: _____

Primary Policy Holder: _____Relationship:_____ Date of Birth:_____

PREFFERED PHARMACY:

Name: _____ Address: _____ Phone: _____

PRIMARY/REFERRING CARE PROVIDER:

Name: _____ Address: _____ Phone: _____

WORKERS COMPENSATION INFORMATION:

Name of Workers Comp Insurance: _____ Adjustor's Name: _____ Date of Injury:_____

Claim Number: _____ Phone Number: _____ Fax Number: _____

CONSENT FOR TREATMENT OF ALL PATIENTS:

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all my medication history including medications prescribed by other providers.

Patient Initials: _____

Sign (Patient or Guardian): _____ **Date:** _____

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Medical History Form

Please complete all the information below in print and check all that applies, please do not leave any questions blank. Thank you!

MEDICAL HISTORY: *Check any of the following that you currently have*

- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal
- ☐ Disease
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizure
- ☐ None
- ☐ Other

Have you had a *Flu Vaccine* this season (October – March 31st)? YES / NO Height: _____ Weight: _____

PAST SURGICAL HISTORY: *Have you had any of the following surgeries?*

- ☐ Organ Transplant: Organ: _____ Year: _____
- ☐ Joint Replacement: Joint: _____ Year: _____
- ☐ Other: _____
- ☐ None

SKIN DISEASE HISTORY: *Have you had any of the following?*

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
  Yr: _____ Location: _____
  Yr: _____ Location: _____
  Yr: _____ Location: _____
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
  Yr: _____ Location: _____
  Yr: _____ Location: _____
- ☐ Atypical/Dysplastic Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
  Yr: _____ Location: _____
  Yr: _____ Location: _____
  Yr: _____ Location: _____

Do you wear sunscreen? YES / NO ***If yes,*** what SPF? _____ Have you tanned in a salon? YES / NO

Do you have a **FAMILY** history of Melanoma? YES / NO ***If yes,*** which relative? _____

MEDICATIONS: ***please list all (or attach)***

_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS: ***please list all***

_____
_____
_____
_____
_____

SOCIAL HISTORY

Smoking Status *(please choose one):*

- ☐ Current, every day smoker
- ☐ Current, occasional smoker
- ☐ Former smoker
- ☐ Never smoked

Alcohol Intake *(please choose one):*

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Sign (Patient or Guardian): _____ **Date:** _____

VIVIDA DERMATOLOGY

PROTECTED HEALTH INFORMATION:

I authorize **VIVIDA DERMATOLOGY**, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. Without authorization, no information may be shared. I authorize **VIVIDA DERMATOLOGY** to disclose my protected health information to the following people.

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES: *Please initial next to one of the following statements*

I would like to **receive** a copy of **VIVIDA DERMATOLOGY** "Notice of Privacy Practices" today and agree with these privacy policies. _____

Patient Initials

I **declined** a copy of **VIVIDA DERMATOLOGY** "Notice of Privacy Practices" today and agree with these privacy policies. _____

Patient Initials

FINANCIAL RESPONSIBILITY/TERMS OF SERVICE

I hereby authorize the office of **VIVIDA DERMATOLOGY** to release any medical information required during examination and treatment to my insurance company, and I permit payment to **VIVIDA DERMATOLOGY** from my insurance for any benefits due for their services rendered. We submit all insurance claims as a courtesy. If your claim is denied, the claim is your responsibility whether or not your insurance company pays. I authorize **VIVIDA DERMATOLOGY** to send any specimen to an outside lab. Vivida Dermatology will make every effort to send specimen to labs within the insurance network.

I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible, and non-covered services. I understand that it is my responsibility to notify Vivida Dermatology of any changes in insurance, mailing address, and phone number(s).

I understand it is my responsibility to understand my insurance benefits. I am responsible to obtain any referrals required by my insurance.

I understand that I am responsible for all charges incurred regardless of the insurance status. However, totals provided upon check-out are only an **ESTIMATE.** I agree to pay my bill in full for services rendered by **VIVIDA DERMATOLOGY.**

NON-PAYMENT ON ACCOUNT

Accounts that are over 45 days past due will receive a call or email stating that you have 14 days to pay your account in full. Please beware that if a balance remains unpaid, Vivida Dermatology may refer your account to a collection agency. If your account is assigned to a collection agency, you agree to pay all expenses Vivida Dermatology may incur in collecting the delinquent balance.

For general **Medical Records** request, there is a $.60 per page fee to be charged at 5 or more pages. For all **FMLA Paperwork**, there is a $50 fee. However, this does not guarantee the FMLA paperwork will ensure your time off will be approved. If you fail to show for your appointment or cancel within 24 hours of your appointment, you will be charged a $25.00 "No Show" fee for general dermatology. For all surgery or procedure appointments, there is a $50.00 "No Show" fee.

_____

Patient Initials

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Sign (Patient or Guardian) Date:

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Quality Measures (65years and older)

Date: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Vaccination Status

Have you received a Pneumonia Vaccination? Yes / NO

Advance Care Planning

Do you have a healthcare proxy in the event you are unable to make your medical decisions? Yes / NO

Designee's Name: _____ Phone Number: _____

Do you have a living will? Yes / NO

Please ***initial*** next to one of the statements that best reflects your wishes on advanced care:

_____ Do not intubate I do not wish to have any breathing tube, even if it is necessary to save my life.

_____ Do not resuscitate if my heart were to stop, I do not wish to have any chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

_____ Full cardiopulmonary Resuscitation (CPR): I want full cardiopulmonary resuscitation efforts to be made