Castle Rock Dermatology, PC

Medical History

Name:_____ DOB:_____ Date:_____

Reason for today's visit _____

Did your physician refer you? Yes No

Are you **allergic** to any medicines? Yes No If yes please list:_____

Have you ever had a bad reaction to dental anesthesia (novacaine) or skin anesthesia (lidocaine) Yes No

For Women: are you o Pregnant o Breast feeding o Trying to become pregnant

What is your occupation:_____
Do you have any hobbies where your hands come into contact with glues/solvents/plants?_____

Medical History: circle any positives:

Hepatitis/Liver Disease	Diabetes	Bleeding Tendency	HIV
Heart Disorders	Cancer (not skin)	Artificial joint or valve	Pacemaker/defibrillator
High Blood Pressure	Thyroid Disease	Organ Transplant	Eczema
Emotional Disorder	Kidney Disease	Neurological Disease	Asthma

Other:_____

Have you had any surgeries or serious illness? When? _____

Skin History:
Have you ever had (circle) Basal Cell or Squamous Cell Cancer / Melanoma / Biopsied Abnormal Moles?

First degree relative (parent, child, or sibling) with a history of Melanoma? Who? _____

Please list your prescription medications followed by your non-prescription medicines:_____

_____

Please initial if we have your permission to try to import your medicines from your pharmacy _____

Social History:

Do you drink alcohol	Y	N	In the last month, have you experienced:		
Smoke tobacco	Y	N	Unexpected weight loss	Y	N
Use Sun screen	Y	N	Fevers	Y	N
Tanning bed in the past	Y	N	Swelling of lymph glands	Y	N
Tanning bed currently	Y	N	Crusting, bleeding, or non-healing lesions	Y	N

If I am unable to be reached directly by phone, I authorize you to leave voice messages for benign results for me at the following numbers.
Home Phone: (____) _____ Cell Phone (____) _____Work Phone(____)_____
Other (____)_____
Can we discuss medical conditions with any member of your household? Y N If yes, whom?_____

I affirm that the above information that I have given is correct.

_____
Patient signature (or legal guardian if applicable)

Castle Rock Dermatology, PC
Patient Registration

Patient's Name: _____ **Date of Birth**:_____ **Age**: _____ __Male __ Female
First Name MI Last Name

Street Address: _____

City/State/Zip Code: _____ **Home Phone: (_____)** _____

Star the best phone to call. Cell Phone (_____)_____ **Other Phone** (_____)_____

Responsible Party: _____ **Relationship:** __Self __Spouse __Parent __Other:_____

Street Address: _____

City/State/Zip Code: _____ **Home Phone: (_____)** _____

Date of Birth:_____ **Cell Phone: (_____)** _____

If patient is a Minor, are parents: __Married __Divorced Custodial Parent: _____

In case of emergency, contact: _____

Phone Number w/Area Code: _____ **Relationship to Patient:** _____

How did you hear about us? (circle one) doctor, insurance web site, phone book, AAD, AOCD dex online, newspaper, family, friend, other

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ **Phone Number:** _____

>>Primary Insured's Name: _____ **>>Date of Birth:** _____

Insured's Street Address: _____

Insured's City/State/Zip Code: _____ **Home Phone: (_____)** _____

Group Name (Employer):_____

ID #:_____ **Group #:**_____ **Relationship:** _____

Insurance Company # 2:_____ **Phone Number:** _____

>>Primary Insured's Name: _____ **>>Date of Birth:** _____

Group Name (Employer):_____

ID #:_____ **Group #:**_____ **Relationship:**_____

- **Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not with your insurance company. Therefore all charges are ultimately your responsibility, regardless of your insurance status. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.**
- **I understand that if I did not produce a valid insurance card, I am financially liable for the entire amount of services incurred today and I will also be responsible for filing my own insurance claim.**
- **I understand that if I did not get a referral from my PCP prior to being seen today, and my insurance requires that I do so, I will personally be responsible for the entire amount of direct and/or ancillary charges related to this visit.**
- **I agree to pay all collections costs and attorney fees that may be incurred to enforce the collection of any amounts outstanding.**
- **I authorize the release of any medical or other information necessary to process this claim, or any claims in the future. I also request payment of government benefits either to myself or to Castle Rock Dermatology, PC.**
- **If appointments are changed or canceled with less than 24 hour notice, a $20.00 cancellation fee will be charged. A $50 fee will be charged for a missed surgical appointment.**
- **I have read the above policy regarding my financial responsibility to Castle Rock Dermatology, PC for providing services to me or the above named patient. I authorize my insurer to pay any benefits directly to Castle Rock Dermatology.**

>>_____ _____

>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

Castle Rock Dermatology, PC

Receipt of Notice of Privacy Practices – Written Acknowledgment Form

I, _____, **have been offered** a copy of Castle Rock Dermatology's Notice of Privacy Practices for review, (Also available on our web site).

_____ _____

Signature of Patient Date

Dear Patients:

No Show Policy

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we acan accommodate our other patients. You may also reschedule your appointment at that time.

Our no-show policy is as follows:

- Our office rarely runs behind – this is because we do not overbook appointments in anticipation of cancellations. We therefore strictly enforce our no-show policy.
- A 24 hour notice is required.
- The first no-show or short notice cancellation will result in a charge of $20.00 for the time slot we were not able to fill when you were a no show.
- *PLEASE NOTE*: If your scheduled appointment was for surgery in our office without exception you will be charged $50.00 for your missed appointment.
- On the second no –show or late cancellation appointment, it will be up to the Doctor's discretion as to whether a discharge letter will be sent disengaging you from the practice.

I _____have reviewed the above policy.

Date_____