

Castle Rock Dermatology, PC  
Medical History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Reason For Today's visit: \_\_\_\_\_

Did your physician refer you? Yes No Do you want us to send an office note to your Doctor? \_\_\_\_\_  
Doctors name \_\_\_\_\_ Office and address \_\_\_\_\_

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 Pregnant Breast Feeding 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-prescriptions medications: \_\_\_\_\_

Please initial if we have your permission to try to import your medicines from your pharmacy. \_\_\_\_\_

Social History:

Do You Drink Alcohol	Y N
Smoke Tobacco	Y N
Use Sun Screen	Y N
Tanning Bed in the past	Y N
Tanning Bed Currently	Y N

In the last month, have you experienced:

Unexpected weight loss	Y N
Fevers	Y N
Swelling of lymph glands	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 Ph: (\_\_\_\_\_) \_\_\_\_\_ Cell Ph: (\_\_\_\_\_) \_\_\_\_\_ Work Ph (\_\_\_\_\_) \_\_\_\_\_

Can we discuss medical conditions with any member of your household? \_\_\_\_\_ 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

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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

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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 can 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 \_\_\_\_\_