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New Patient Registration

Today's Date: ___/___/___

Name: ___ (First) ___ (Middle) ___ (Last) ___ (Suffix)

Date of Birth: ___/___/___ Sex: [F] [M] Marital Status: [Single] [Married] [Other]

Address: _____

(City) (State) (Zip)
(Home phone) (Cell phone) (E-mail address) By providing this, I authorize this office to contact me via email.

These questions are included to comply with Federal Health Guidelines – We are required to ask this information

Ethnicity (check one) [Hispanic or Latino] [Not Hispanic or Latino] [I choose not to specify]

Race (check one) [American Indian/Alaskan Native] [Asian] [Black/African American] [White]
[Native Hawaiian/Other Pacific Island] [I choose not to specify] [Other]

Preferred Language (check one) [English] [Spanish] [American Sign Language]
[I choose not to specify] [Other]

How did you hear about us? _____

Primary Care Physician: _____ Phone: (____) ____ - ____

DO YOU HAVE HEALTH INSURANCE? [YES] [NO] IF YES, PLEASE PROVIDE BELOW

Primary Insurance: _____ Phone: (____) ____ - ____

Policy Owner: _____ Date of Birth: ___/___/___

Member ID: _____ Group #: _____

Secondary Insurance: _____ Phone: (____) ____ - ____

Policy Owner: _____ Date of Birth: ___/___/___

Member ID: _____ Group #: _____

Please present your insurance card(s) and your photo I.D. to the receptionist who will make a copy for your file and return them to you

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of our financial policies. PAYMENT IS EXPECTED FROM YOU FOR "YOUR PORTION OF THE CHARGES" AT TIME OF SERVICE. For your convenience, we accept CASH, DEBIT, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER and CARE CREDIT. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the release of necessary medical information to process your insurance claims (if any) and herein authorize payment of medical benefits to the provider when an assigned claim is filed.

____ (Signature) _____ (If signature is not from patient, please provide name and relation) ___/___/___ (Date)

Financially Responsible Party (legal guardian, power of attorney, etc.....)

____ (Relation) _____ (Print Full Name) _____ (Sign)

Address: _____

Phone: (____) ____ - ____



OFFICE POLICIES

Thank you for choosing Spencer Dermatology and Skin Surgery Center for your dermatology needs. We recognize that you have a choice in health care providers and we appreciate the trust that you have placed in us. The following details our office policies and allows us to provide excellent health care to all of our patients in an office atmosphere based on mutual respect. Please review and **initial next to each** office policy summary acknowledging that you have read and understand the policy.

(initial) Your first visit, or any visit in which you will provide our office with an insurance update, will require you to arrive 15 minutes prior to your appointment time in order to complete the new patient registration process or update your insurance information. We will obtain a photocopy of your current insurance card and photo I.D.

(initial) We respect your time. We try our very best to stay on schedule, but occasionally a patient requires more than the allotted amount of time due to urgent or complicated problem. Thank you for understanding that we will provide this same level of attention to you in the event that you should have the same need.

(initial) **We have a same day appointment policy. In the event that you have an urgent health care problem that requires immediate attention, we will see you in the office that day. In order to accommodate patients in this manner, our office requires 24 hours notice for cancellations. Appointments cancelled within 24 hours of the appointment will be coded "no-show" and charged a \$25.00 fee. If you need to cancel an appointment after our office is closed, please leave a message with our answering service. We realize that in rare cases you will be unable to provide the required 24 hour notice.**

(initial) If you are going to be more than 15 minutes late for a scheduled appointment, it may be necessary to reschedule. We will make every effort to see you on the day of your appointment, however if the wait time will exceed your availability, we will be happy to reschedule the appointment for you.

(initial) Our office hours are Monday thru Friday from 8:00am to 4:00pm. We provide after hours and weekend call coverage in the event of **EMERGENCIES ONLY**. Our answering service will take the necessary information and call the Provider On-Call. Pages that are not urgent nature **WILL NOT** be returned

(initial) Routine prescription refills will be given during our office hours. Please call your pharmacy to have a request faxed to our office and allow 48 hours (not including weekends) for your request to be refilled.

(initial) Please note that **NO controlled substance** prescriptions can be filled via phone or electronically as per DEA regulations.

(initial) **NOTICE: WE ACCEPT ONLY CASH, CARE CREDIT, CREDIT/DEBIT CARD PAYMENTS FOR COSMETIC TREATMENTS AND PRODUCTS SOLD IN THE OFFICE.**

(initial) I understand that if scheduled with the Certified Physician Assistant, if for any reason I feel that I should be directly consulted by a Physician during my visit, or if the PAC recommends that a MD should become involved in my case, there will be an opportunity for such consultation.

Welcome to Spencer Dermatology. We look forward to the opportunity to work with you to meet your dermatology needs.

I have read, understand and agree to abide by the office policies described above.

Print Patient Name or Legal Guardian

Signature of Patient or Legal Guardian

Date



Patient Medication List

Please fill out as completely as possible.

NAME _____

ALLERGIES TO MEDICATIONS (please include reaction) _____

PREFERRED PHARMACY: _____ **PHONE:** _____

ADDRESS: _____

ALL CURRENT MEDICATION (Please list)

Are you currently taking: ___ Aspirin ___ Coumadin ___ Plavix

- | | |
|-----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |
| 11. _____ | 12. _____ |
| 13. _____ | 14. _____ |
| 15. _____ | 16. _____ |
| 17. _____ | 18. _____ |
| 19. _____ | 20. _____ |

Are you allergic to: **Lidocaine**? Y__ N__ OR **Latex**? Y__ N__

Do you take antibiotics before dental work? Y__ N__

Signature of Patient or Legal Guardian

Date



PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

Spencer Dermatology & Skin Surgery Center will use your medical information for the following:

1. **TREATMENT:** Including providing your medical records to consulting clinicians and your insurance companies.
2. **PAYMENT:** We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical records to pay the claim.
3. **HEALTH CARE OPERATIONS:** Any others involved in your healthcare.

The entire Private Policy Notices of Spencer Dermatology & Skin Surgery Center is available at our front desk for your perusal.

In conjunction with these privacy practices, you will need to provide us with the following information. The information will be the minimum necessary based on the professional opinion of the healthcare provider.

May we leave personal medical information on your Voicemail at home? YES NO

Do you give our office permission to discuss your medical health information with family members? YES NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (____) _____ Phone # (evening): (____) _____

Name: _____ Relationship: _____

Phone # (day): (____) _____ Phone # (evening): (____) _____

Emergency Contact Information:

In case of Emergency, whom should we notify? _____

Relationship to Patient: _____ Phone: (____) _____

Printed Name of Patient or Legal Guardian

Relationship to Patient

Signature

Date

Witness

Date