PATIENT REGISTRATION

Patient Name: ______________________________ Referring Dr. ______________
Primary Dr. ______________

Local Address: ______________________________ How did you hear about us: __________

City: ______________ State: ________ Zip: ____________ **Local phone #:** ______________

Permanent Address: ______________________________ **Permanent #:** ______________

City: ______________ State: ________ Zip: ____________ **Cell #:** ______________

Email: ______________________ Appt reminder Y/N Promotions Y/N

SSN: ______________ Marital Status: (S) (M) (Other) (D) (W) Sex: (M) (F) **Date of Birth:** __________

Emergency Contact: ______________________ Phone: ______________ Relationship: __________

Employment Status: (Full-time) (Part-time) (Unemployed) (Self-employed) (Retired) (Military)

Company: ______________________ Occupation: ______________________

Address: ______________________ City: ______________ State: ________ Zip: ________

Phone #: ______________ Fax: ______________ Contact Person: ______________

Responsible Party/Guardian: _______Patient _______ Other *If other, please complete this section*

Name: ______________________ Home #: ______________

Address: ______________________ Work #: ______________

City: ______________ State: ________ Zip: ____________ Cell #: ______________

Date of Birth: ____________ SSN: ______________ Other # ______________

Employer: ______________________

Insurance Information Do you have medical insurance?_____Yes _____No **Payment** is expected as services are rendered. What means of payment are you prepared to use today? _____Cash ______Check _____Visa/Mastercard _____America Express

Primary: ______________________ Member ID #: ______________ Group #: ______________

Name of Insured as it appears on card: ______________________ Insured's Date of Birth: ______________

Secondary: ______________________ Member ID #: ______________ Group #: ______________

Name of Insured as it appears on card: ______________________

If insured person is other than the patient, please complete the following:

Patient relationship to insured: (Spouse) (Child) (Grandchild) (Niece/Nephew) (Parent)

Name: ______________________ Home #: ______________

Address: ______________________ Work #: ______________

City: ______________ State: ____________ Zip: ____________ Cell #: ______________

Date of Birth: ____________ SSN: ______________________ Other #: ______________

Information, Authorization for Treatment, and Assignment of Benefits

Consent for Treatment: I consent to the care and treatment by Dr. Cabiran and/or Jane Pressler, NP. The treatment may include but is not restricted to medications, anesthesia, surgical and invasive procedures, lab, x-ray, or other studies that may be helpful in the performance of the patient's care.

Authorization for Release of Medical Records: I authorize the release of any of all medical records or information, including psychiatric, drug, alcohol, HIV, and substance abuse records, to the referring physicians or agencies involved in the patient's care, insurance carriers or those involved in the payment of the patient's account, or others involved in the performance of quality assurance.

Assignment of Benefits and Guarantee of Account: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that I am financially responsible for all co-payments and any charges that are not paid by my insurance. I authorize payment directly to Dr. Cabiran, MD and/or Jane Pressler, NP all medical or surgical benefits otherwise payable to me under the terms of my insurance. In the event an account is turned over to a collection agency, I agree to pay all costs of collection including reasonable attorney's fees and hereby waiver all rights of exemption under the Constitution of the State of North Carolina/Georgia, I certify that the information I have reported with regard to my insurance coverage is correct.

Exposure to Diseases: I understand that if my physician(s), or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I am deemed to have consented to the release of these test results to those who were exposed to my body fluids.

A photocopy of the authorization shall be considered as effective and valid as the original.

Circle one:

Patient Signature: ______________________ **(Patient) (Parent) (Guardian)** **Date:** ______________

Highlands Dermatology Medical History

Patient Name:______________________________ Date of Birth:______________

Reason for today's visit: ______________________________

Please mark the condition(s) or disease(s) that you currently have, or have had in the past:

- ☐ Arthritis
- ☐ Asthma
- ☐ A-Fib (Irregular Heartbeat)
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ GERD/Acid Reflux
- ☐ Hepatitis
- ☐ Hypercholesterolemia(High Cholesterol)
- ☐ Hypertension(High Blood Pressure)
- ☐ Hyperthyroidism/☐Hypothyroidism
- ☐ Seizures
- ☐ Stroke
- ☐ Cancer-Type:__________
- ☐ None
- ☐ Other:__________

Please list any surgical procedures you have had in the past 6 months: ☐ None ______________________________

Do you have a family history of the following? Diabetes: ☐ Mother/☐ Father High Blood Pressure: ☐ Mother/☐ Father
Elevated Cholesterol: ☐ Mother/☐ Father ☐ None

Do you currently smoke tobacco? ☐ Yes ☐ No *Have you ever smoked in the past?* ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No *If yes:* ☐ less than 1 drink per day ☐ 1-2 per day ☐ More than 3 per day

Please mark the skin conditions or disease that you currently have, or have had in the past:

☐ Acne ☐ Actinic Keratosis ☐ Blistering Sunburn ☐ Dry Skin ☐ Eczema ☐ Flaking/Itchy Scalp ☐ Poison Ivy ☐ Psoriasis

☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Precancerous Moles ☐ None ☐ Other:__________

☐ Melanoma *Family history of melanoma?* ☐ Yes ☐ No If yes, what is your relationship?__________

Do you use sunscreen regularly? ☐ Yes ☐ No If yes, what SPF? ______ *Do you have an allergy to Neosporin?* ☐ Yes ☐ No

Please list all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

☐ See attached list of medications. ☐ None

____

____

Are you allergic to any medications? ☐ Yes ☐ No *If yes, please list the name of medication and type of reaction below.*

____

Please mark all that apply:

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ Immunosuppression
- ☐ Mole that is changing
- ☐ Experiencing a rash
- ☐ Anxiety
- ☐ Fever or chills
- ☐ Headaches
- ☐ Joint aches
- ☐ Neck stiffness
- ☐ Night sweats
- ☐ Shortness of breath
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Artificial joints within past 2 years
- ☐ Artificial heart valve
- ☐ Require premedication prior to procedures
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotic/ointments
- ☐ Pregnant or planning on becoming pregnant
- ☐ Allergy to Lidocaine
- ☐ Experience rapid heartbeat with Epinephrine
- ☐ Experience yeast infections with antibiotics
- ☐ Experience G.I. upset with
- ☐ Taking a blood thinner (Aspirin, coumadin,plavix etc....)
- ☐ None apply

Please answer to the following questions to comply with The Medicare EHR Incentive Program.

What pharmacy do you use? ______________________ City, State ______________

What is your preferred language: ______________

What is your race? ☐ White ☐ American Indian or Alaskan Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other

What is your ethnicity? ☐ Hispanic or Latino ☐ ***Not*** Hispanic or Latino ☐ Unknown

Patient Signature: ______________________________ **Date:** ______________