Patient ID #: _____

## PATIENT REGISTRATION

Date: _____

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Patient SSN: _____-_____-_____

Occupation: _____

Employer: _____

Emergency Contact

Name: _____Relationship: _____

Phone Number: _____

Date of Birth: ____/____/_____ Sex: Male / Female

Primary Number: _____

Home / Cell / Work

Secondary Phone: _____

Home / Cell / Work

Email: _____

Spouse/Parent Name: _____

Spouse/Parent Employer: _____

Primary Care Provider: _____

Referred By Physician: Yes / No

Physician Name: _____

## BILLING INFORMATION

Payment of insurance copay or for any cosmetic services is expected the day of services are rendered.
We accept MasterCard, Visa, Discover, American Express, Checks, and Cash.

**Responsible Party** (person responsible for any remaining balance due)

Name: _____ Relationship: _____ Date of Birth: _____/_____/_____

Street Address: _____City: _____ State: _____ Zip: _____

SSN: _____-_____-_____ Phone Number: _____ Home / Cell

**Primary Insurance Name**: _____

Name: _____ Relationship: _____ Date of Birth: _____/_____/_____

Home Address: _____City: _____ State: _____ Zip: _____

SSN: _____-_____-_____ Phone Number: _____ Home / Cell

**Secondary Insurance Name**: _____

Name: _____Relationship: _____ Date of Birth: _____/_____/_____

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

SSN: _____-_____-_____ Phone Number: _____ Home / Cell

**PLEASE COMPLETE THIS FORM FRONT AND BACK**

## PAYMENT POLICY

Payment of all co-pays is due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances. If you should have any. Our mission is to provide you with the highest quality dermatological care possible. With this in mind, we are constantly trying to control our costs while conforming to the standard fee schedules approved by most major insurance companies. Our receptionist will need to verify your insurance coverage prior to your visit. .

1. Any outstanding balances should be paid before your office visit or procedure, unless prior payment arrangements have been made.

2. Your insurance is a contract between you and the insurance company. While we accept the reimbursement rates of many insurance companies, we are not a party to your contract and do not determine which are medically necessary services that they cover and which they do not.

3. We require payment in full on the date of service for co-pay and offices charges defined under your policy as your responsibility.

4. A $40 administrative fee for delayed payment will be added to your balance if you choose not to pay at the time services are rendered. This $15 fee is not billable to your insurance company; it is your responsibility. To avoid this fee, you must pay at the time of service.

5. We expect you to call us if you are not able to make it your appointment. For your convenience, we may make an attempt to remind you of your appointment. Your appointment is a reservation of the office' staff and provider's time and resources.

We realize that on occasion, temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact the billing department in our office for assistance.

**I hereby authorize direct payment of surgical/medical benefits to Musick Dermatology & Advanced Clinical Spa, LLC for services rendered by the physician or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance and if necessary reasonable attorney and court fees incurred to collect said professional fees due to Musick Dermatology & Advanced Clinical Spa, LLC for medical services rendered to me.**

**Patient Signature/Parent of Legal Guardian: _____ Date: _____**

## PROTECTED HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Musick Dermatology & Advanced Clinical Spa, LLC to use and disclose health information about you for treatment, payment and health care operations purposes.
**Notice of Privacy Practices:** Musick Dermatology & Advanced Clinical Spa, LLC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.
**Amendment:** We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

**I have received the Notice of Privacy Practices for Musick Dermatology & Advanced Clinical Spa, LLC and authorize Musick Dermatology & Advanced Clinical Spa, LLC to release and obtain health information about me from other physicians and medical facilities for continued care.**

**I hereby authorize Musick Dermatology & Advanced Clinical Spa, LLC to discuss any medical information for the treatment of my care. Person(s) to whom information may be disclosed below: spouse, parent(s), legal guardian, or other.**

_____ _____

Name of person/Relationship Name of person/Relationship

**Patient Signature/Parent of Legal Guardian: _____ Date**: _____

## MEDICAL HISTORY

Drug Allergies: _____

_____

Latex Allergy: Yes / No  Local Anesthetic (Xylocaine) Allergy: Yes / No

Chronic Illness: _____

_____

Past Surgeries: _____

Do you have any artificial joints: Yes / No  Mitral valve prolapse or artificial heart valve: Yes / No

Alcohol Intake: _____

Smoking History: _____

Family Diseases: _____

_____

## SKIN DISEASE HISTORY

Check All That Apply:

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ NONE
- ☐ OTHER: _____

_____

Do you wear sunscreen? Yes / No
Do you tan in a tanning salon? Yes / No
Do you have a family history of Skin Cancer? Yes / No  If yes, which relative(s)?_____

## REVIEW OF SYSTEMS

Do you have any recent problems with the following? If yes, please describe in this space.

Fevers/Chills/Weight loss? ……. Yes / No
Sore eyes/Dry eyes? ……....Yes / No
Sores in mouth or nose? …….....Yes / No
Chest pains/Leg swelling? ……Yes / No
Burning urination/Frequent urination? …….Yes / No
Muscle or joint pains? ……...Yes / No
Numbness of feet/Dizziness? ……Yes / No
Depressed/Anxious mood? ……. .Yes / No
Fatigue/Cold intolerance? …… Yes / No
Swollen lymph glands? …….Yes / No
Runny nose/Stuffy head/Asthma? ……Yes / No

## MEDICATION LIST

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

| Name of Medication | Dosage | Frequency |
|---|---|---|
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## PHARMACY INFORMATION

Preferred Pharmacy

Name: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____