

**PATIENT REGISTRATION**

(Please print)

Date: \_\_\_\_\_

Acct: \_\_\_\_\_

Name \_\_\_\_\_  
Last First (MI)

Date of Birth \_\_\_\_\_

Street \_\_\_\_\_

Male  Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Patient SSN \_\_\_\_\_

Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

Email \_\_\_\_\_

Spouse's/Parent's Name \_\_\_\_\_

Personal Physician \_\_\_\_\_

Spouse's/Parent's Employer \_\_\_\_\_

Referred By Physician Yes/No

**PAST/FAMILY/SOCIAL HISTORY**

Drug Allergies \_\_\_\_\_

Latex Allergy Yes/No

Allergy to Local Anesthetic(Xylocaine) Yes/No

Current Medication - Dose - Frequency or Provide List \_\_\_\_\_

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 \_\_\_\_\_

Family History of Skin Cancer \_\_\_\_\_

**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 Pain/Leg Swelling..... Yes/No
- Nausea/ Diarrhea.....Yes/No
- Burning Urination/Frequent urination?..Yes/No
- Muscle or joint pain?.....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

**FULL EXAM**

We will provide a full-body skin examination if you choose Yes/No.  
This service is particularly recommended if you have a history of blistering sunburns,  
more than 40 moles or if anyone in your family has had skin cancer

**PLEASE COMPLETE THIS FORM FRONT AND BACK (TURN OVER TO CONTINUE)**

**BILLING INFORMATION**

**Payment of insurance copay or for any cosmetic services is expected the day services are rendered.  
We accept MasterCard/Visa/Discover/AmericanExpress/Check/Cash**

**Person responsible for any remaining balance due. Example: Self / Parent / Guardian**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Phone # \_\_\_\_\_ SSN \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PRIMARY INSURANCE NAME** \_\_\_\_\_ **Amount of Co-pay** \_\_\_\_\_

**POLICYHOLDER'S INFORMATION:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SSN \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

**SECONDARY INSURANCE NAME** \_\_\_\_\_

**POLICYHOLDER'S INFORMATION:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SSN \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

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.

**ALL INSURANCE AND MEDICARE**

I hereby authorize Musick Dermatology & Advanced Clinical Spa, LLC. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

**PROTECTED HEALTH INFORMATION**

I hereby authorize Musick Dermatology & Advanced Clinical Spa, LLC. to release or obtain from other physicians and medical facilities whatever records are necessary for my continued care.

\*Patient signature, Parent or Legal Guardian \_\_\_\_\_ DATE \_\_\_\_\_

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: spouse, parent(s), legal guardian, or other.

\_\_\_\_\_  
Name of person/relationship/phone #

\_\_\_\_\_  
Name of person/relationship/phone #

# HIPAA PATIENT CONSENT FORM

Musick Dermatology & Advanced Clinical Spa, LLC Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, a new Notice will be available at the reception desk or you may obtain a revised copy by contacting our office at 4948 Benchmark Centre Dr., Swansea, IL 62226 or (618)628-2588.

You have the right to request that Musick Dermatology & Advanced Clinical Spa, LLC restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. Musick Dermatology & Advanced Clinical Spa, LLC is not required to agree to this restriction, but if we do, Musick Dermatology & Advanced Clinical Spa, LLC shall honor that agreement.

By signing this form, you consent to Musick Dermatology & Advanced Clinical Spa, LLC's use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Musick Dermatology & Advanced Clinical Spa, LLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- Musick Dermatology & Advanced Clinical Spa, LLC has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Musick Dermatology & Advanced Clinical Spa, LLC reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but Musick Dermatology & Advanced Clinical Spa, LLC does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Musick Dermatology & Advanced Clinical Spa, LLC may condition receipt of treatment upon the execution of this Consent.

**Name of Patient:** \_\_\_\_\_

**Signature of Patient or Legal Representative** \_\_\_\_\_

**Date:** \_\_\_/\_\_\_/\_\_\_

**If signed by someone other than the patient:**

**Print Name:** \_\_\_\_\_

**Relationship to Patient (if other than patient):** \_\_\_\_\_

**Date:** \_\_\_/\_\_\_/\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Medication List**

Name of Medication	Dosage	Frequency

**Date Reviewed/Initials**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____