PATIENT REGISTRATION

(Please print)
Date:_____ Acct:_____

Name_____
Last First (MI)

Street_____

City_____ State_____ Zip_____

Patient SSN_____

Occupation_____

Employer_____

Spouse's/Parent's Name_____

Spouse's/Parent's Employer_____

Date of Birth_____

☐ Male ☐ Female

Home Phone_____

Cell Phone_____

Work Phone_____

Email_____

Personal Physician_____

Referred By Physician Yes/No

PAST/FAMILY/SOCIAL HISTORY

Latex Allergy Yes/No

Allergy to Local Anesthetic(Xylocaine) 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_____

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_____

DATE: _____ ID#: _____

MUSICK DERMATOLOGY | SKINCEUTICALS ADVANCED CLINICAL SPA

PATIENT NAME: _____

DATE OF BIRTH: _____

Please list any **drug allergies** we should be aware of:
(if the patient does not have any drug allergies, please write NONE)

_____

MEDICATIONS

Please provide all current prescriptions and over-the-counter drugs.
If patient is not taking any medications, please write NONE.

Date last reviewed: (Nurses and Providers ONLY)

Name of Medication	Dosage (ie: 20mg)	Route of Administration (ie: orally or topically)	Frequency (ie: once daily)

_____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____

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 in accordance to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice contains a Patient Rights section describing your rights under the law. You have the right to review out Notice before signing this consent. The terms of our Notice are subject to 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 located at 4948 Benchmark Centre Drive, Swansea, IL 62226 or by calling (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 HIPAA guidelines.

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:** ___/___/_____

ID#: _____

PATIENT NAME:_____

EMAIL:_____

PHONE NUMBER:_____

Can we leave messages with number provided above regarding appointment/test results?

YES / NO

PATIENT INFORMATION RELEASE

I authorize the person(s) listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case.

I have the right to terminate this agreement at any time by informing the staff in writing.

(If there is no one you would like your information released to, please write none in the first box)

AUTHORIZED PERSON(S)	RELATIONSHIP TO PATIENT	PHONE NUMBER

Signature of Patient or Legal Representative confirming above information is correct:

Name:_____ Date: _____