Patient Registration / History Form

Patients Full Name: _____
Social Security #: _____-____-_____Date of Birth: _____/_____/_____ Pt Sex: ❒ Male ❒ Female
Address: _____ Preferred Pharmacy: _____
City: _____ State: _____ Zip:_____ Employer: _____
Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell Phone: (____) _____-_____
If under 18, Guarantors Full Name: _____
If Student: ❒ Full Time ❒ Part Time Name of School: _____
Pri Insurance / PPO:_____ ID #:_____ Owner: _____ DOB:_____
Sec Insurance / PPO:_____ ID #:_____ Owner:_____ DOB:_____

Do you have a history of:

Melanoma	❍ Yes	❍ No	Problems with local anesthetic	❍ Yes	❍ No
Other skin cancer	❍ Yes	❍ No	Diabetes	❍ Yes	❍ No
Abnormal moles	❍ Yes	❍ No	Glaucoma	❍ Yes	❍ No
Bleeding problems	❍ Yes	❍ No	Tanning bed use	❍ Yes	❍ No
Other skin conditions	❍ Yes	❍ No	Specify:_____		

❍ Yes ❍ No : Do you use any tobacco products? Specify_____
❍ Yes ❍ No : Do you have a pacemaker?
❍ Yes ❍ No : Do you take aspirin or ibuprofen? (If yes, how often: _____)
❍ Yes ❍ No : Have you been told you need antibiotics before dental procedures? (if yes, please explain)
_____
❍ Yes ❍ No : Has anyone in your family had melanoma? Relationship:_____
❍ Yes ❍ No : Has anyone in your family had other forms of skin cancer? _____
❍ Yes ❍ No : Has anyone in your family had a history of any other skin condition? (please specify below)

Please list your current medications (including non-prescription medications) **and Date** (update each visit**)**
As of ___/___/____ _____
As of ___/___/____ _____
As of ___/___/____ _____
As of ___/___/____ _____

Allergies:_____

May we have your permission to:

Leave a message on your answering machine at home?	❍ No	❍ Yes	Initial: _____
Call you at your place of ❍ employment / ❍ cell phone?	❍ No	❍ Yes	Initial: _____
Discuss your medical condition with any member of your household?	❍ No	❍ Yes	Initial: _____

(if yes, please list whom and your relationship to them)
Contact: _____ Relationship _____ Phone: _____
Contact: _____ Relationship _____ Phone: _____

In case of emergency, who should be notified?
Name(s)_____ Relationship_____
Phone #: (_____) _____-_____ Alt. Phone #: (_____) _____-_____

Who is your primary care physician? _____Phone# _____

Please complete the information on the reverse side

By signing below, I verify the patient demographic information on the front is accurate and acknowledge that I have reviewed, understand and freely agree to the statements below.

PATIENT CONSENT

I consent to the rendering of routine medical care which may include diagnostic procedures and medical treatment that my physician and other health care personnel at Iowa Dermatology, Incorporated consider necessary. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as to the result of the examination or treatment.

EXPOSURE TO BLOOD BORNE PATHOGENS

I hereby acknowledge that according to the Code of Iowa, in the event an employee of Iowa Dermatology, Incorporated is exposed to my blood or body fluids, a sample of my blood will be tested for HIV (the virus that causes AIDS), hepatitis B and hepatitis C. This testing will be done at no cost to me.

FINANCIAL AGREEMENT

In the event that I am entitled to payments arising out of a policy of insurance or similar agreement, the payments are hereby assigned to Iowa Dermatology, Incorporated for application on the patients' bill. I and/or the patient hereby agree to be responsible for and pay any and all charges that are not covered by insurance or for which the insurance company refuses to pay or indicates is the patient's responsibility. Payment for charges on non-covered services are expected at the time services are rendered.

RELEASE OF INFORMATION

I authorize Iowa Dermatology, Incorporated to release information needed to substantiate payment for my medical care to those who are financially liable. I also authorize Iowa Dermatology, Incorporated to release treatment related information to myself and/or health care providers for continued care.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received and/or reviewed a copy of Iowa Dermatology, Incorporated's Notice of Patient Privacy Practices.

I understand the content of this form and its significance.

Patient/Responsible Party

Signature:_____ Date:_____

Updated / Reviewed

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____