Patient Registration Form

Please bring insurance card and photo ID to your appointment

Patient Name_____ **Date of Birth**_____ **Today's Date**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Cell #**_____ **Work #** _____

Circle your contact preference: Home phone Cell phone Work phone Email
Email_____ **I do not have email** _____
May we send you an email appointment reminder? Yes_____ **No** _____

How were you referred to our practice?

- ☐ **PCP? Please indicate your PCP's name:** _____
- ☐ **Other MD? Please indicate name and reason:** _____
- ☐ **Friend?** _____
- ☐ **Web site?** _____
- ☐ **Advertisement?**_____

Please give us the following information to facilitate our communication with your Primary Care:
Primary Care Name (first/last)_____ **City**_____ **Did your doctor give you an insurance referral for our office Yes No** _____

Primary Insurance_____ **Policy #**_____ **Group** _____

Secondary Insurance_____ **Policy #**_____ **Group** _____

Policy Holder Name_____ **Policy Holder DOB**_____ **Relationship**_____

Race: White_____ **African American**_____ **American Indian**_____ **Asian**_____

Hispanic/Latino_____ **Non Hispanic/Latino**_____ **refused to answer**_____

I have been able to review the Krauss Dermatology Notice of Privacy Practices (available in our office or on our website). This notice provides information about how Krauss Dermatology may use and disclose my protected health information, what its legal duties are regarding my protected health information, and what my rights are regarding my protected health information, and how I can file a complaint about these privacy practices. I understand that if I have additional concerns, I may ask the HIPAA compliance officer at Krauss Dermatology for clarification.

Yes_____ **No**_____ **Signature**_____ **Date** _____

Welcome to Krauss Dermatology

Please read the following before your visit:

The landscape of healthcare delivery and medical insurance has changed greatly over the last few years. Many of our patients now have high deductible plans, significant copay for visits and restrictions on prescriptions covered. It is a challenge for doctor's offices and patients to keep track and understand these changes. We strive to work with our patients in delivering cost effective medical care, but need your help.

Please **familiarize yourself with your health plan and prescription plan before you visit our office. You may require a referral from your primary care doctor**, particularly if you have an "HMO" plan. If you do not obtain this referral, your insurance company may refuse to cover your visit and you will be responsible for the charges.

If you have a **significant deductible**, you may be billed for the cost of your visit. This is not the same as having no coverage. We will bill your insurance first. If you have a deductible, your insurance company will adjust our charges to what your own insurance company believes I "reasonable and customary." There is generally a charge for the visit (evaluation and management) and additional charges for procedure such as biopsy of a suspicious lesion, or treatment is necessary, there will be additional charges at the subsequent visits. If a biopsy is done, the tissue is sent to Strata DX where it will be processed and read by board certified dermatopathologists. A separate bill will be sent to your insurance company from Strata DX, and any copays or deductible will be your responsibility.

Unfortunately skin tags, age spots (seborrheic keratosis), and normal age related changes such as freckling are now considered cosmetic concerns by the insurance companies. Their removal is not considered medically necessary and is not covered by insurance. If you desire removal of skin tags or age spots, these lesions can often be removed by our physicians for an additional charge payable at the time of the visit.

When you pick up prescription medications at your pharmacy, and the cost of the medication seems very high, discuss this with your pharmacist. We always attempt to prescribe the most cost effective medication available. However, some medications which may be beneficial to you may not be available as a generic, and may not be covered by your insurance. If this is the case, please call our office to see if there is a less expensive alternative we can substitute.

To facilitate communication with our office, sign up for the Partners Patient Gateway to allow secure email and access to some aspects of your medical record. Go to www.patientgateway.org and be sure to choose your doctor (in our practice) in order to enable a link to our practice. You may request prescription refills, leave a message for your physician or have a general question left at this site and someone from our office will get in touch with you. Appointments cannot be booked here nor is our schedule posted at this time. As always you can call our office for appointments, with a question, or to request prescriptions refills. Please note most prescription refills require a visit within 1 year of the request.

Signature _____ Date _____

Printed Name _____ Date of Birth _____

Patient Name: _____ Date of Birth: _

Please read and darken the circles for the appropriate response regarding your medical history.

Female Patients Only

Currently Pregnant	O Yes	O No
Currently Breastfeeding	O Yes	O No

General

Allergies to Medication	O Yes	O No
Problems with anesthesia	O Yes	O No
History of Cancer	O Yes	O No

Constitutional

Recent fever or chills	O Yes	O No

Eyes

Vision Problems	O Yes	O No

Neurological

Frequent or Severe Headaches	O Yes	O No
Numb/Tingling Hands or Feet	O Yes	O No

Endocrine

Diabetes	O Yes	O No
Always Tired/Sluggish	O Yes	O No

Gastrointestinal: Recent or Frequent

Abdominal Pain	O Yes	O No
Nausea/Vomiting	O Yes	O No
Indigestion/Heartburn	O Yes	O No

Cardiovascular

Pacemaker	O Yes	O No
Chest Pain	O Yes	O No
Varicose Veins	O Yes	O No
High Blood Pressure	O Yes	O No
Heart Valve Problem	O Yes	O No

Musculoskeletal

Joint Replacement	O Yes	O No
Joint Pain/ Arthritis	O Yes	O No

Ear/Nose/Throat: Recent or frequent

Ear Infection	O Yes	O No
Sinus Problems	O Yes	O No
Eye Pain/Discomfort	O Yes	O No
Wheezing/ Asthma	O Yes	O No
Frequent Cough	O Yes	O No
Hay Fever	O Yes	O No

Hematologic/ Lymphatic

Bleeding Problems	O Yes	O No
Blood Clot or Stroke	O Yes	O No

Psychologic

Anxiety Disorder	O Yes	O No
Mood Swings	O Yes	O No
Depression	O Yes	O No

Have you or a family member ever had the following?

Melanoma	O Yes	O No	Family Member/self? _____
Other Skin Cancer	O Yes	O No	Family Member/self? _____
Psoriasis	O Yes	O No	Family Member/self? _____
Eczema/Dermatitis	O Yes	O No	Family Member/self? _____
Moderate or severe Acne	O Yes	O No	Family Member/self? _____

Darken the circle if the answer is yes:

O Smoke

O Drink alcohol more than 4 drinks per week?

O Currently work? Occupation_____

O Live Alone?

O Wear sunscreen Regularly?

O Tan Regularly (tanning booth or outdoors)?

Why we ask: In dermatology, many conditions may be related to work exposures such as chemicals or intense sun. Also, recuperation from some medical or cosmetic procedures may interfere with work related tasks or public appearances. In addition, patients who live alone may need to have skin exams more frequently if we are following lesions on the back, or may need assistance with dressing changes after a procedure.

Patient Name: _____ Date of Birth:_____

Please list any prescription medication you are regularly taking:

_____ _____

_____ _____

_____ _____

Please list any nonprescription medication you are regularly taking:

_____ _____

_____ _____

Please list any medication allergies (with type, such as hives, stomach upset) environmental or skin allergies:

_____ _____

_____ _____

Please describe any medical problems you checked “yes” to on the prior medical history sheet, or any other medical issues you have that were not listed:

_____ _____

_____ _____

_____ _____

_____ _____

Please list prior surgeries with approximate date of procedure:

_____ Date_____

_____ Date_____

_____ Date_____

Pharmacy Name_____**Address** _____

Phone #_____**Fax #** _____

We appreciate your time and effort in completing these forms. The information will help us treat you safely and effectively

Patient Authorization for Practice to Share Protected Health Information

For our patients over the age of 18 we are unable to discuss or disclose appointment and treatment information including all prescription and prescription refills. If there are individuals with whom you would like us to be able to discuss this information, please fill out this form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Patient name:_____ Date of Birth:_____

Specific description of the information to be used or disclosed:

- ☐ All medical information including, results such as biopsy and blood tests, treatments, and general visit information
- ☐ Specific information only: _____

Individuals who may receive and use the disclosed information:

Name and relationship: _____

Name and relationship: _____

Expiration date of this authorization:

- ☐ No expiration
- ☐ Until date specified: _____

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

Signature of patient or representative:_____ Date_____

This authorization was signed by:_____ Date_____

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Practice Representative/Witness: _____