

Castle Rock Dermatology, PC

Medical History

Name: _____ DOB: _____ Date: _____

Reason for today's visit: _____

Did your physician refer you? Yes _____ No _____

Are you **allergic** to any medicines? Yes No If yes please list: _____

Have you ever had a bad reaction to dental anesthesia (novacaine) or skin anesthesia (lidocaine) Yes No

For Women: are you Pregnant Breast feeding Trying to become pregnant

What is your occupation: _____

Do you have any hobbies where your hands come into contact with glues/solvents/plants? _____

Medical History: circle any positives:

Hepatitis/Liver Disease	Diabetes	Bleeding Tendency	HIV
Heart Disorders	Cancer (not skin)	Artificial joint or valve	Pacemaker
High Blood Pressure	Thyroid Disease	Organ Transplant	Eczema
Emotional Disorder	Kidney Disease	Neurological Disease	Asthma

Other: _____

Have you had any surgeries or serious illness? When? _____

Skin History:

Have you ever had (circle) Basal Cell or Squamous Cell Cancer / Melanoma / Biopsied Abnormal Moles?

First degree relative (parent, child, or sibling) with a history of Melanoma? Who?: _____

Please list your prescription medications followed by your non-prescriptions medicines: _____

Social History:

Do you Drink Alcohol	Y N
Smoke Tobacco	Y N
Used IV drugs	Y N
Exercise	Y N

Have you experienced (Review of Systems):

Unexpected weight loss	Y N
Fevers	Y N
Swelling of lymph glands	Y N
Crusting, bleeding, or non-healing lesions	Y N

Please fill in the phone numbers you would like us to contact you with biopsy and lab results.

Home Ph: (_____) _____ Cell Ph: (_____) _____ Work Ph: (_____) _____

Can we leave benign biopsy or blood work results on your home/cell answering machine? _____

Can we discuss medical conditions with any member of your household? _____ if yes whom? _____

I affirm that the above information that I have given is correct.

Patient signature (or legal guardian if applicable)

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Patient Registration

Patient's Name: _____ SS #: _____
First Name MI Last Name

Date of Birth: _____ Age: _____ Male Female

Street Address : _____

City/State/Zip Code: _____ Home Phone: (____) _____
Cell Phone: (____) _____ Work Phone: (____) _____

Responsible Party: _____ Relationship: Self Spouse Parent Other: _____

Street Address : _____

City/State/Zip Code: _____ Home Phone: (____) _____

If patient is a Minor, are parents Married Divorced Custodial Parent: _____

Custodial Parent's Home Phone: (____) _____ Work Phone: (____) _____

Custodial Parent's SS #: _____ Date of Birth: _____

In case of emergency, contact : _____

Phone Number w/Area Code: _____ Relationship to Patient: _____

How did you hear about us? (circle one) doctor, insurance web site, phone book, AAD, AOCD dex online, newspaper, family, friend, other

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Insured's Street Address : _____

Insured's City/State/Zip Code: _____ Home Phone: (____) _____

Group Name (Employer): _____

ID #: _____ Group #: _____ Relationship: _____

Insurance Company # 2: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Group Name (Employer): _____

ID #: _____ Group #: _____ Relationship: _____

- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not with your insurance company. Therefore all charges are ultimately your responsibility, regardless of your insurance status. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.
- I understand that if I did not produce a valid insurance card, I am financially liable for the entire amount of services incurred today and I will also be responsible for filing my own insurance claim.
- I understand that if I did not get a referral from my PCP prior to being seen today, and my insurance requires that I do so, I will personally be responsible for the entire amount of direct and/or ancillary charges related to this visit.
- I agree to pay all collections costs and attorney fees that may be incurred to enforce the collection of any amounts outstanding.
- I authorize the release of any medical or other information necessary to process this claim, or any claims in the future. I also request payment of government benefits either to myself or to Castle Rock Dermatology, PC.
- If appointments are changed or canceled with less than 24 hours notice, a \$20.00 cancellation fee will be charged.
- I have read the above policy regarding my financial responsibility to Castle Rock Dermatology, PC for providing services to me or the above named patient. I authorize my insurer to pay any benefits directly to Castle Rock Dermatology.

>> _____
>>Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) _____ Date _____

