The Dermatology & Skin Care Center of Birmingham
2470 Rocky Ridge Road, Suite 100, Birmingham, AL 35243
Phone (205)978-3336 Fax (205) 503-4915
www.bhamdermatology.com

New Patient Registration

Patient Information

____ _________________
First, Middle, Last Name Date of Birth

____
Address

_______________________ _____________________ _________________
Home Telephone Cell Phone Social Security Number

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single Sex: ☐ Male ☐Female

Preferred Name (Nickname): ____

Responsible Party Email: ________________________________(may be used for billing notifications)

Patient Email:____(for patient portal)

Employment Information

Employment Status: ☐ Employed ☐ Part-Time ☐ Full-time student ☐ Other

___________________________ _________________________ __________________
Occupation Employer Work Phone

Insurance Information

Name of Insurance: _________________________________ Policy #_________________________

________________________________ __________ ______________ ________________
Name of Insured Date of Birth Social Security Number Relationship to Patient

Emergency Contact (Not living in home of Patient)

_________________________________ __________________ _______________________
Name Phone Number Relationship to Patient

Is your illness related to any of the following?
☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident ☐ No

Have you been seen by Dr. Harper, Rebecca Edwards, CRNP, or Katie Tuck, CRNP before? ☐ Yes ☐ No

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and/ or treatment.

____ _________________________
Signature of Patient or Other Legally Authorized Person Date

Primary Care Physician: ___________________________________ Phone/Fax:_________________

Referring Physician: ______________________________________ Phone/Fax:_________________

Pharmacy Information

_____________________________ _______________________________ ___________________

Name Address Phone/ Fax

Reason for your visit: ____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
Cancer: ________________
Specify
Treatment:_____________

COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis

High Blood Pressure
HIV/AIDS
High Cholesterol
Hypothyroidism
Hyperthyroidism
Seizures
Stroke
NONE

Other:____

Past Surgical History

Appendix Removed
Bladder Removed
Mastectomy: (R, L, Both)
Lumpectomy: (R, L, Both)
Breast Biopsy: (R, L, Both)
Breast: Reduction or Implants
Colectomy: (Colon Cancer Resection, Diverticulitis, IBD)
Gallbladder Removed
Coronary Artery Bypass

Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement Knee: (R, L, Both)
Joint Replacement Hip: (R, L, Both)
Kidney Biopsy
Kidney Removed: (R, L)
Kidney Stone Removal
Kidney Transplant

Ovaries Removed: (Endometriosis, Cyst, Ovarian Cancer)
Prostate: (Cancer, Biopsy, TURP-removal)
Spleen Removed
Testicles Removed: (R, L, Both)
Hysterectomy: (Fibroid, Uterine Cancer)
NONE

Other: ____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin

Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy

Abnormal Moles
Psoriasis
Squamous Cell Skin Cancer
NONE

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _______
Do you tan in a tanning salon? ☐ Yes ☐ No

Family History

Has any blood relative ever had: If so, who?

Melanoma ☐ Yes ☐ No ___________________
Other Skin Cancer ☐ Yes ☐ No _____________
Cystic Acne ☐ Yes ☐ No _________________
Psoriasis ☐ Yes ☐ No ______________________

Current Medications (Include all Prescriptions and Over the Counter)

Medication Name	Strength	Dose (How Many)	Frequency

I give The Dermatology and Skin Care Center of Birmingham permission to access my medications from my pharmacy. ☐ Yes ☐ No If yes, please initial here _____________

Allergies: (Please write all allergies)

____

____

Medication Allergies: ____

Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Have you had your Flu Vaccine? ☐ Yes ☐ No If yes, when? ___________________________________

Have you had your Pneumonia Vaccine? ☐ Yes ☐ No If yes, when? _____________________________
If "no" please consult your Primary Care Physician to determine whether or not you need the Pneumonia Vaccine.
Please initial that you have read the above statement regarding the pneumonia vaccine and understand._________

Social History: (Please check all that apply)

Cigarette Smoking: ☐ Currently Smokes ☐ Never Smoked ☐ Former Smoker
Alcohol Use: ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Review of Systems

Do you have or have you ever had: (Please check Yes or No and give details)
Not Checking a response is considered a "No" answer.

Excess Bleeding ☐Yes ☐No _____________
Artificial Heart Valve ☐Yes ☐No _____________
Artificial Joint ☐Yes ☐No _____________
Blood Clots ☐Yes ☐No _____________
Chest Pain ☐Yes ☐No _____________
HIV ☐Yes ☐No _____________
Hepatitis ☐Yes ☐No _____________
Skin Rashes ☐Yes ☐No _____________
Cancer ☐Yes ☐No _____________
Chronic Cough ☐Yes ☐No _____________
Shortness of Breath ☐Yes ☐No _____________
Pigment Lesions ☐Yes ☐No _____________
Thyroid Disorders ☐Yes ☐No _____________
Diabetes ☐Yes ☐No _____________

Frequent Nausea ☐Yes ☐No ___________
Constipation ☐Yes ☐No ___________
Weight Loss ☐Yes ☐No ___________
Anxiety/Depression ☐Yes ☐No ___________
Mouth Sores ☐Yes ☐No ___________
Frequent Urination ☐Yes ☐No ___________
Organ Transplant ☐Yes ☐No ___________
Allergies ☐Yes ☐No ___________
Moles ☐Yes ☐No ___________
Immunosuppression ☐Yes ☐No ___________
Fever or Chills ☐Yes ☐No ___________
Bloody Stool ☐Yes ☐No ___________
Bloody Urine ☐Yes ☐No ___________
Joint Aches ☐Yes ☐No ___________

Please inform your healthcare provider of any cultural or spiritual issues that may affect your care.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY

The Health Insurance Portability & Accountability Act of 1966 ("HIPAA") is a federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you the right to understand and control how your personal health information ("PHI") is used.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe that your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Pay for your health services
- Administer your health plan
- Comply with the law
- Address workers' compensation, law enforcement, and government requests
- Respond to lawsuits and legal actions

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check no response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing or call our staff)

Spouse: ____ ☐ Yes ☐ No

Parent: ____ ☐ Yes ☐ No

Other: ____ ☐ Yes ☐ No

Preferred method of contact: ☐ Home ☐ Mobile ☐ Work ☐ Email _________________________________

Is it ok to leave Voicemail? ☐ Yes ☐ No

Printed Name: ____

Patient/Parent/Guardian Signature: ____________________________________ Date: ________________

FINANCIAL POLICY

The Dermatology and Skin Care Center of Birmingham believes that communicating our financial policy is a good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. We will file your primary and secondary insurances only. Please realize that having a secondary insurance does not necessarily mean that your services are covered at 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur. You can complete a "Credit Card on File" form for us to use for up to one year for recurring charges/account balances.

You are responsible for all copays, coinsurance, deductibles, and non-covered services/items. We are obligated to collect your deductible/co-insurance and/or copay at the time of service per your insurance company. Statements are sent out monthly, and we ask that payment for balances due be rendered when you receive your statement. There is a $35 return check service charge. Payment will then need to be made for the balance due and the service charge.

Balances not paid within 90 days will be turned over to outside collection agency unless prior payment arrangements have been made. Accounts turned over to collections will incur a $12.50 service fee for collection proceedings. In addition, any account 60 days past due can be restricted from making further appointments. However, we do understand that some patients accrue large balances for services provided. We will work with these patients to set up a mutually feasible payment plan. Please understand that we cannot waive deductibles, coinsurance or copays that are required by your insurance. This is a violation of our contracts with the insurance plans.

Completing disability forms, FMLA forms, Cancer Policy's and other requested forms requires time away from patient care and day to day business operations. Prepayment of $10 per form is required. Please understand that in order to complete these forms your medical record must be reviewed, forms completed, signed by the physician and incorporated into your medical record. We request that you allow 5 business days for this process.

In order to provide you with the best care possible we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. Any patient that does not keep their appointment and does not notify the office at least 24 hours in advance will be billed $25 for each missed appointment.

I understand and agree to The Dermatology & Skin Care Center's Financial Policy.

Print Name ____ Date ____________________

Signature____

To our patients:
In our effort to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time you check in. This information will not be used until your insurances have paid their portion and notified both you and us how much, if any, of your portion/balance has been paid. At that time, any remaining balance owed by you will be charged to your credit card on file.

____

Authorization for Credit Card on File Payment

Until further notice, I authorize The Dermatology and Skin Care Center of Birmingham to charge the patient –responsible balances on my account and the following individuals accounts to the below credit card.

Please check card type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Last 4 digits of my credit card: ______ ______ _____ _______

Expiration Date: __________________ Signature Code: ____________ Billing Zip Code: ___________

Is the card on file a Health Savings Account (HAS) or Flex Spending Account (FSA)? ☐ Yes ☐ No

Individuals that this card can be used on:

____Relationship _________________________

____Relationship _________________________

____Relationship _________________________

____Relationship _________________________

If any balance after my insurance pays is over $25, I understand that I will receive a courtesy call or email before my card is charged.

Signature: ____ Date: _________________________

Full Name on Card (Please Print) ____

Email ____