CURRENT DERMATOLOGY
NEW PATIENT REGISTRATION FORM

Today's Date _____

Patient Information

Patient's Last Name | Patient's First Name | Middle Initial

_____

Preferred or "Goes By" Name

Prefix (please circle)
Ms Miss
Mrs
Mr Sir Dr
Unknown

Suffix (please circle)
Jr Sr
I II III IV
V

Date of Birth _____/_____/_____
Month Day Year

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Other

Patient or Guardian (for minor children) Social Security Number: _____ -- _____ -- _____

Birth Sex:
☐ Male ☐ Female

Gender Identity:
☐ Male ☐ Female ☐ Transgender ☐ Other

Preferred Pronoun: ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Their

Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Other (specify) _____

Ethnic Group: ☐ Hispanic ☐ Not Hispanic/Latino

Language: ☐ English ☐ Spanish ☐ Other: (specify) _____

Contact Methods

Preferred Contact Method
☐ Phone/Text ☐ Email ☐ Fax ☐ Postal
☐ Other (specify) _____

Home Phone # ( )

Mobile Phone # ( )

Work Phone # ( )

Is it ok to leave a detailed message in a voicemail?
☐ Yes ☐ No

Would you like to have access to your online patient portal?
☐ Yes ☐ No (If yes, please provide email address below)

Would you like to receive email appointment reminder notifications? ☐ Yes ☐ No

Email Address

Emergency Contact Name:

Contact's Phone ( )

Relationship to patient:

Patient's Primary MAILING ADDRESS Information (for billing/statements)

Street Address

Address Line 2

City | State | Zip

Patient ALTERNATE ADDRESS Information (i.e. Part-time resident - if applicable)

Street Address

Address Line 2

City | State | Zip

Patient Name:	Date of Birth:

Patient's Insurance Information

Primary Insurance Company Name		
	Primary ID #	Primary Group #
Insured's Name	Insured's Date of Birth	
Secondary Insurance Company Name		
	Secondary ID #	Secondary Group #
Insured's Name	Insured's Date of Birth	
Tertiary Insurance Company Name		
	Tertiary ID #	Tertiary Group #
Insured's Name	Insured's Date of Birth	

Preferred Pharmacy Name	City
Primary Care Physician Name	City
Referring Provider Name	City

PROTECTED HEALTH INFORMATION RELEASE:
Concerning matters of my health, lab results, and appointments, I, the patient/legal representative, give permission for Dr. Patterson or members of her staff to speak and share my information with:

Name	Phone ( )
Relationship to patient:	
Name	Phone ( )
Relationship to patient:	

☐ **I DO NOT WANT TO SHARE MY INFORMATION WITH ANYONE**

PATIENT NAME: Date of Birth:

CONSENTS for TREATMENT

ADULT PATIENT

General Consent for Care and Treatment

I, hereby authorize Current Dermatology physician, providers, staff and its representatives to render routine dermatologic care.

I understand that routine health care is confidential and voluntary and may involve provider office visits which include history taking, examinations, administration of medications, laboratory tests, and/or minor procedures including biopsies. Please note also that Current Dermatology routinely uses photography for patient recognition and monitoring and location purposes. I understand that I may discontinue services at any time.

I understand that a full body skin cancer screening is NOT considered a PREVENTIVE SCREENING by insurance.

Signature of Patient:	Date:

******Please fill below for CONSENT TO TREAT a MINOR******
Responsible Party - General Consent for Care and Treatment

MINOR PATIENT

Consent for Care and Treatment of MINOR: (only complete if patient is a minor)

I, _____, hereby authorize Current Dermatology's physician, providers
(Responsible Party Name - PRINT)
assistants, staff and its representatives to render routine dermatologic care to minor patient

_____ _____ _____-_____-_____
(Responsible Party Full Name - SIGNATURE) (Responsible Party Date of Birth) (Responsible Party Social Security Number)

*****Every patient has a legal right to refuse consent or to withdraw consent for any proposed treatment at any time. Please ask to sign a "Request to Withdraw Treatment Consent" form and a notation will be made in the patient's chart*******

Patient Name: Date of Birth:

Financial Policy and Signature on File

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Current Dermatology.

I understand that I am financially responsible for all services rendered and for the following reasons: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company. ***Failure of payment from any insurance company does not excuse the patient's financial responsibility. It is the patient's responsibility to know what is and is not covered.***

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances.

Medicare: We will file claims for you. Please note that Medicare will not pay for a variety of procedures that they do not consider medically necessary. Payment is expected at time of service for them.

Medicaid: For all Medicaid patients, we require a signed valid card and the co-payment at each visit (unless a minor). *If you don't have a valid card, we will need to reschedule your appointment.*

Surgery Patients/Patients who have biopsies: We will file insurance for your surgery. However, you will receive a separate bill from the laboratory for pathology.

Cosmetic Procedure: Payments are required at time of service.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Patient/Responsible Party Signature**X**_____Date_____

HIPAA COMPLIANCE STATEMENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Current Dermatology we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the practice's Privacy Officer at (828) 631-1852.

Signature**X**_____Date_____

PATIENT MEDICAL HISTORY

Patient Name:	Date of Birth:

Reason for today's visit:

Please let us know of any **medication allergies or sensitivities** that you may have. If so, please tell us what happened when you took the medication. For example, "Penicillin - Hives". If "none", please simply indicate "No Allergies".
MEDICATION ALLERGIES OR SENSITIVITIES: _____

Have you ever had any reaction to dental numbing medications? ☐ Yes ☐ No

If yes, what was your reaction? _____

Please list which medications you are currently taking. **(We only need the name not the exact dosage)**
Please include vitamins and/or supplements:

1.	2.	3.	4.
5.	6.	7.	8.

Have you ever been diagnosed with skin cancer? ☐ Yes ☐ No If "yes", please tell us as many details about it as you can, including what type of cancer was it, where on your body, how and when it was treated and by whom:

_____

_____

Have you been diagnosed with any other skin condition? ☐ Yes ☐ No. If "yes", please explain:

Have your **parents, siblings or children** been diagnosed with **melanoma?** ☐ Yes ☐ No. If "yes", who?

Do you have (or have had in the past) any of the following conditions? Please check all that apply:

☐ ASTHMA	☐ ARTHRITIS	☐ COPD/EMPHYSEMA	☐ DIABETES
☐ ALZHEIMER'S/DEMENTIA	☐ CANCER (Other than skin) Type: _____	☐ THYROID DISORDER	☐ HIGH BLOOD PRESSURE
☐ HEART ATTACK	☐ GLAUCOMA	☐ EPILEPSY/SEIZURES	☐ BLEEDING DISORDER ☐ I take BLOOD THINNERS
☐ ORGAN TRANSPLANT	☐ HX OF FAINTING	☐ HIV/AIDS	☐ HEPATITIS
☐ LUPUS	☐ OTHER AUTOIMMUNE CONDITION		

Do you have: ☐ PACEMAKER/DEFIBRILLATOR ☐ ARTIFICIAL HEART VALVE ☐ HEART MURMUR ☐ ARTIFICIAL JOINT
If you checked any of the above, do you need to take antibiotics prior to any dental/surgical procedures? ☐ Yes ☐ No

Any other medical history we should know about?

Do you …. Smoke ☐ Yes ☐ No. If "yes", for how many years?_____ How many packs/day? _____
Drink Alcohol? ☐ Yes ☐ No. If "yes", how many drinks and how often? _____
Use "recreational" or "IV" drugs? ☐ Yes ☐ No. If "yes", please list:_____
Use Tanning Beds? ☐ Yes ☐ No, If "yes", how often? _____
Wear sunblock regularly? ☐ Yes ☐ No

WOMEN: Are you pregnant? ☐ Yes ☐ No, If "yes", are you breastfeeding? ☐ Yes ☐ No
If you are NOT pregnant, are you trying to become pregnant? ☐ Yes ☐ No

If you are interested in laser treatments (for wrinkles, unwanted hair, or blood vessels), Botox or Fillers, than feel free to ask Dr. Patterson or any member of our staff for more information.

61 Bonnie Lane
Sylva, NC 28779
Phone: 828-631-1852 / Fax: 828-631-2534

243 Jones Cove Road, Clyde, NC 28721
828-627-9616

196 Riverview Street, Franklin, NC 28734
828-631-1852

"NO-SHOW" CHARGE AGREEMENT

At Current Dermatology, our goal is to provide quality care in a timely manner. Please be courteous and notify Current Dermatology promptly if you are unable to attend an appointment. This time will then be offered to someone in the community who is in urgent need of treatment.

The following policy is regarding patients who fail to keep their scheduled appointment. A "No-Show" is an appointment that was not canceled in advance, within at least 24 hours' notice. Patients who fail to show for their scheduled appointment or have not notified the office within 24 hours prior to their scheduled time may be subject to a "No-Show" fee.

- The "No-Show/Cancellation" fee for a missed appointment is **$50.00**.
- This fee is not covered by insurance and is therefore the responsibility of the patient.
- In the event of an actual emergency whereas prior notice could not be given, consideration will be given, and depending on circumstances, exceptions may be granted.

HOW TO CANCEL YOUR APPOINTMENT

To cancel or reschedule your appointment, please call Current Dermatology at 828-631-1852. In the event that our lines are busy or your call goes to our office VoiceMail, please leave a message. Your early cancellation will give another patient the possibility to have access to timely care.

I acknowledge the above and agree to adhere to these guidelines.

Patient/ Guardian
Signature_____Date_____

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Late Patient Agreement

We appreciate the effort our patients make to arrive before the scheduled appointment time to allow time to fill out paperwork, update demographics and make payments. Patients are expected to arrive 15 minutes ahead of their appointment time. Our providers strive to run as close to booked appointment times as possible. This process will ensure patients that do arrive on time are seen in a timely manner.

If a patient arrives more than 15 minutes late for their appointment time, the patient will be given the option of either waiting to be seen, if the schedule permits (there is a no show or cancellation same day) or rescheduled for a later date. If a patient is late to an appointment, future appointments may be scheduled at day's end in order to prevent delays to other patients.

I acknowledge the above and agree to adhere to these guidelines.

Patient/ Guardian
Signature_____Date_____