

# Patient Registration Form

<b>Location</b> Westlake Office Middleburg Heights Office Lorain Office	<b>Patient Name</b>	<b>Sex</b> Male      Female	<b>Date of Birth</b>
<b>Ethnicity</b> Hispanic Non-Hispanic Unknown	<b>Race</b> White    Black or African America Asian American Indian / Alaska Native Native Hawaiian / Other Pacific Islander Other    Declined	<b>If "Other," Please Explain</b>	<b>Preferred Language</b>
<b>Address</b>	<b>Home Phone Number</b>	<b>Cell Phone Number</b>	<b>Social Security Number</b>
<b>Drivers License Number</b>	<b>Employer</b>	<b>Occupation</b>	<b>Email Address</b>
<b>Work Phone Number</b>	<b>Appointment Reminders</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Specials, Events, etc.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>How did you hear about us?</b> Doctor    Insurance    Radio    Magazine    Friend    Internet / Website Billboard    Other		<b>If Other please explain</b>	

## Emergency Contact

<b>Emergency Contact Name</b>	<b>Relationship of Patient</b>	<b>Address</b>	<b>Phone Number</b>
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## Guarantor Information Responsible Party

<b>Is the patient responsible for charges?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	If someone other than patient, please provide information in this section	<b>Guarantor Name</b>	<b>Relationship to Patient</b>
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<b>Guarantor Date of Birth</b>	<b>Guarantor Phone Number</b>	<b>Guarantor Social Security Number</b>	<b>Guarantor Address</b>
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## Primary Insurance Information

<b>Policy Holder</b>	<b>Insurance Name</b>	<b>Phone Number</b>	<b>ID Number</b>
<b>Group / Account Number</b>	<b>Subscriber Name</b>	<b>Subscriber Date of Birth</b>	<b>Relationship to Patient</b>
<b>Subscriber's Social Security Number</b>	<b>Subscriber's Address</b>		

**Do you have secondary insurance information?**

Yes     No

## Secondary Insurance Information

<b>Policy Holder</b>	<b>Insurance Name</b>	<b>Phone Number</b>	<b>ID Number</b>
<b>Group / Account Number</b>	<b>Subscriber Name</b>	<b>Subscriber Date of Birth</b>	<b>Relationship to Patient</b>
<b>Subscriber's Social Security Number</b>	<b>Subscriber's Address</b>		

## History and Intake Form

<b>Patient Name</b>	<b>Date of Birth</b>	<b>Race</b>	<b>Ethnicity</b>	<b>Preferred Pharmacy Location</b>
<b>Primary Care Physician</b>	<b>Referring Physician</b>	<b>Preferred Pharmacy Name</b>	Decline Hispanic Non-Hispanic	

### Past Medical History

NONE

Anxiety    Arthritis    Asthma    Atrial Fibrillation    Autoimmune Disease    Cerebrovascular Accident (Stroke)

Chemotherapy    COPD    Depression    Diabetes    Thyroid Disease    End-stage Renal Disease    Hay Fever

Hypertension    Hearing Loss    Heart Disease    HIV/AIDS    High Cholesterol    Immunosuppressive Therapy

Hepatitis    Leukemia    Lymphoma    Colon Cancer    Myocardial Infarction (Heart Attack)    Radiation Therapy

Seizure    Other

<b>Pneumonia Vaccinations</b>	<b>Quality measures</b>
Administered this flu season	Full-code   DNI
Administered previous flu season	Living will
Administered previous flu season	DNR

If "Other" Please Explain

### Past Surgical History

NONE

Pacemaker / Defibrillator    Artificial Joint    Tubal ligation    Heart Valve Replacement    Hysterectomy

Oophorectomy    Transplantation of Kidney    Transplantation of Lung    Transplantation of Heart    Transplantation of Liver

Other

<b>Artificial Joint : Year</b>	<b>Heart Valve Replacement :</b>	<b>If "Other" Please Explain</b>
	<input type="checkbox"/> Biological <input type="checkbox"/> Mechanical	

### Skin Disease History

NONE

Acne    Actinic Keratosis    Basal Cell Carcinoma    Dry Skin    Dysplastic / Atypical Moles    Eczema

Melanoma    Psoriasis    Rosacea    Squamous Cell Carcinoma    Sunburn of Second Degree (Blistering)    Other

If "Other" Please Explain

<b>Do you wear sunscreen?</b>	<b>If Yes, what SPF?</b>	<b>Do you tan in a tanning salon?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Do you have a family history of Melanoma?</b>	<b>If yes, which relative (s) ?</b>
Yes   No	

### Current Medications

Do you take current medications?

Yes   No

list any medications that you are currently taking. Include items such as aspirin, vitamins, laxatives, etc.

<b>Name of medication</b>	<b>Dose (strength and # per day)</b>
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**Do you give us permission to request prescription history information electronically from your pharmacy?**

Yes      No

**Allergies / Sensitivities**

**Allergies for medication?**

Yes     No

**Name of medication**

**Reaction**

**Social History**

**Smoking Status**

Current every day smoker     Current some day smoker     Former smoker     Never smoker

**Weekly Alcohol Intake**

None     Casual drinker or less than 1 drink per day     1-2 drinks per day     3 or more drinks per day

**How many times per year do you have 5+ drinks in one day?**

**Flu Vaccination**

Administered this flu season     Administered previous flu season     I do not/have not gotten the flu vaccine

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**Patient Financial Liability Form**

**Insurance**

Patients are responsible for providing accurate and timely insurance information to our office. Patients will be held financially liable for services rendered if the correct insurance information is not provided within the required filing period for their insurance. Verification of benefits or prior authorization is not a guarantee that an insurance carrier will pay a claim. The insurance carrier makes the final determination upon receiving the claim, based upon the plan's level of coverage and associated policies. Denied claims become the responsibility of the patient. Patients are fully responsible for obtaining any necessary referral from another physician before the appointment time. Insurance claims denied due to lack of referral will become the patient's responsibility.

Co-payments are due and payable at the time of service. If we are unsure of copay liability, we will bill the insurance first then the patient will be billed for any applicable co-payments. The patient agrees to pay all deductibles, coinsurance, and services deemed "patient responsibility" as identified by the insurance carrier. Payment in full is due upon receipt of the statement unless prior arrangements are made with the billing office.

Associates in Dermatology, Inc. accepts Visa, MasterCard, Discover, checks, or cash. Checks returned for nonpayment will be subject to additional fees. Unpaid patient balances may be placed with an outside Collection Agency if payment is not made within 90 days. This may adversely affect your credit. Non-emergent medical services may be denied until delinquent balances are paid.

**Cosmetic Services**

All Cosmetic services are payable in full at the time of service.

**Biopsies / Pathology**

A biopsy may be necessary during the course of your treatment. If a biopsy is needed, you will be billed separately by a Pathologist for the processing and interpretation of each specimen. We are unable to quote fees for pathology services.

**No-Show Appointments**

If you are unable to keep your appointment, please notify our office by phone or e-mail no less than 24 hours before your appointment. Messages are acceptable and can be left at all times, including evenings and weekends. Associates In Dermatology may assess a \$75 fee for an appointment that is missed without adequate notice. I have read the above information and agree to the terms contained therein:

**Patient or Parent / Guardian Signature**

**Patient's PRINTED Name**

**Date**

**Parent / Guardian PRINTED Name (If patient is a minor)**

## Notice and Acknowledgement

I acknowledge that I have received the attached Notice of Privacy Practices.

Patient or Personal Representative Signature

Patient or Personal Representative

Date

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If Personal Representative's signature appears above, please describe Personal Representative relationship to the patient

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## Authorization to Disclose PHI (Personal Health Information)

Patient Name

## Disclose PHI to

Disclose PHI Name

Home Phone Number

Ext

Mobile Phone Number

Ext

OK to leave a voice mail?

Yes  No

OK to discuss results?

Yes  No

Relation to Patient

Spouse  Parent  Child  Friend  Other

If "Other" Please Explain

Signature

Name

Date

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## Privacy Policy

Associates In Dermatology is committed to respecting our visitors' privacy and protecting their personal information from misuse or unauthorized disclosure and complying with privacy laws. Associates In Dermatology values its reputation and aims to maintain high ethical standards in the conduct of our business affairs.

Associates In Dermatology ("us", "we", or "our") operates [www.healthyskinmd.com](http://www.healthyskinmd.com) (the "Site"). This page informs you of our policies regarding the collection, use, and disclosure of Personal Information we receive from users of the Site. We use your Personal Information only for providing and improving the Site. By using the Site, you agree to the collection and use of information in accordance with this policy.

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## What information do we collect?

When filling in forms or calling the phone number listed on the website as appropriate, you may be asked to enter or provide your name, postcode and, email address and telephone number.

We will not collect any information about you without your explicit consent.

We will ask your consent every time we need to collect personal information about you.

We will explain in clear simple terms why we want to collect your information and what we will do with it, before seeking your consent, so you are fully informed. You will be given a clear and unambiguous option to opt in to any communications or services we might want to offer you.

All data is collected directly from you, the individual. We do not collect any of your personal data from any other sources. This includes any publicly accessible lists and or data sources, whether in the public domain or if we have a legitimate interest to be able to access those sources legally.

## What do we use your information for?

Any of the information we collect from you may be used in one of the following ways:

- Identify you as a user in our system
- Provide you with the Services and complete your transactions;
- Provide you with customer support;
- Help understand your needs and tailor the features and content of the services to you;
- Respond to and, as applicable, fulfill your requests, resolve disputes and/or troubleshoot problems;
- Send you administrative e-mail notifications, such as security, or support and maintenance advisories;
- Send newsletters, surveys, offers, and other promotional materials related to our Services and for other marketing purposes;
- Improve the quality and functionality of the services;
- Share with our third-party software and services providers in order to facilitate our communications; and Communicate with you about our services.
- Any and all data in respect of – 'What Information Do We Collect?' is not subject to any automated decision making. We do not profile you using your data, any actions taken by us or our systems are as a direct result of explicit requests or consents you have chosen.

There are no foreseeable consequences of any significance in respect of providing the data or being removed from the records, except that we will not be able to contact you.

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## How do we protect your information?

We will store and process your data following industry best practices and security.

We will take all reasonable steps to ensure that there are appropriate arrangements in place that include provisions covering the appropriate secure transfer, handling and processing of the personal information by those entities and third parties.

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## Do we use cookies?

Yes. Refer our Cookie Policy. Visit: [COOKIE POLICY](#)

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## Do we disclose any information to outside parties?

We do not sell, trade, or otherwise transfer to outside parties your personally identifiable information. This does not include trusted third parties who assist us in operating our website, conducting our business, or servicing you. Where processing takes place by one of our trusted data processors, we ensure that our contracts with those third parties contain the appropriate GDPR / PIPEDA model clauses and that all our third parties are also compliant with the GDPR, PIPEDA this affords your data the same protection away from our organization, as it does within it.

We may also release your information when we believe release is appropriate to comply with the law, enforce our site policies, or protect ours or others' rights, property, or safety. However, non-personally identifiable visitor information may be provided to other parties for marketing, advertising, or other uses.

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## Third party links

Occasionally, at our discretion, we may include or offer third party products or services on our website. These third-party sites have separate and independent privacy policies. We therefore have no responsibility or liability for the content and activities of these linked sites. Nonetheless, we seek to protect the integrity of our site and welcome any feedback about these sites.

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## Your rights as an individual in respect of the data we hold

We respect the rights and freedom of individuals and as such, we would like to make you aware of the following.

You have the right to:

- Request access to your data
- Request rectification of your data where there are errors or inaccuracies, or the data is not current
- Request that the data we hold is removed entirely from our systems
- Request us to restrict processing your data
- Object to our processing your data
- Request your data in a format that is commonly used/accepted
- Send your data to another controller
- Withdraw consent already provided – at any time

You also have the right to complain or withdraw your consent. To exercise your above rights, send a written request to [policy@pri-pol.com](mailto:policy@pri-pol.com)

**Signature**

**Name**

**Date**