Nelson Dermatology
REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital	
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑	❑	❑	❑ self pay	❑
❑	❑	❑	❑	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Assignment & Release:
I, the undersigned, have coverage with _________________________ and assign directly Nelson Dermatology PLLC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I financially responsible for all charges whether or not paid by insurance. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. I authorize the use to this signature on all insurance submissions.
Patient/Guardian Signature______________________________ Date:_______________________

I understand and agree that I am personally responsible for all charges incurred regardless of my insurance coverage n the event that my account is referred to an attorney for collections, I agree that in addition to the balance owed, I will be responsible for collection and attorney fees in addition to the balance owed. Payment for the services rendered or to be rendered in the future is irrevocably and unconditionally guaranteed by guarantor whose signature appears below, together with interest thereon and all late charges, attorney fees cost and expenses of collection incurred in enforcing any of such liabilities.
I agree that all above information is correct to the best of my knowledge.
Financial Responsible Party
Patient /Guarantor Signature_______________________________ Date: ___________________

Policies and Procedures Agreement

It is our goal to provide you the best dermatologic care we possibly can. Part of your care includes the billing of your insurance provided we've received the correct and complete information from you. If complete information is not provided at the time of your visit, you will be billed. Please read the following information as it will answer many of your questions regarding our billing policies.

All Patients: Are expected to have their current insurance card, valid picture ID, co-pay, co-insurance and any balance at the time of service.

HMO/Managed Care plans/Tricare: IT IS YOUR RESONSIBILTY to make sure a current referral has been obtained prior to appointments with our office. If no referral has been obtained, you appointment will be rescheduled. It is THE PATIENTS RESPONSIBILITY to make sure the correct referral is in place if you are having testing performed. If you still desire to be seen without proper authorization, you will then be binded to our practice self-pay fees.

Co-pays: Primary and secondary insurance co-pays must be paid at the time of check- in. Patients will be asked to reschedule if they do not have their co-pay. If the co-pay is not paid at the time of visit there will be a $25.00 billing fee added.

Patient Information and insurance cards: Your personal information sheet and insurance card are an important part of your medical record. It is your responsibility to make sure that you update this information at each visit to keep your record current. As this may seem inconvenient, it is necessary to keep you insurance and contact information update to insure you receive proper care.

Late Policy: Every effort is made to keep our physician schedule on time, therefore if you are more than 15 minutes late, we will reschedule your appointment to the next available in the office; however, there is no guarantee that you will be seen immediately. If the physician schedule is full you will be asked to reschedule your appointment to a later date.

Transferring of Records: All patients must sign a records release form to have their records copied or to send them to another provider or organization. Copies will be provided to the patient for a $10.00 fee administrative fee PLUS $0.50 per page up to 50 pages and then $0.25 per page thereafter. There is no fee to transfer records directly to another provider or organization.

Collections: Patients that have an unresolved balance will be sent to collections. Patients will then accure an additional collection fees. Patients are expected to resolve all balances and /or collection issues before setting up their next appointment. Nelson Dermatology does not permit patients to carry balances. If patient balances are not addressed, patients are running a risk of being discharged from the practice.

No Shows: Failure to cancel an appointment within 24 Hours will result in a **$50.00** no show fee and for any procedure that is not canceled you will be charged **$75.00**.

Please remember a confirmation call is a courtesy done by this office and not an obligation, therefore will not be a reason to waive a no- show fee.

I have read, understand and accept the above financial policy. Understand that charges not covered by my insurance company, as well as applicable co-payments, co- insurances and deductibles are my responsibility. I understand that it is my responsibility to contact my insurance carrier(s) if they do not respond to payment request made on my behalf.

Financial Responsible Party
Patient/Guarantor Signature:_______________________________ Date:_________________

HIPPA Authorization:

I, the undersigned, authorize Nelson Dermatology PLLC to speak with the person(s) and/or Provider(s) listed below regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by Nelson Dermatology PLLC to the listed person(s)/ provider(s) and thereby release Nelson Dermatology PLLC and their staff from all legal responsibility that may arise from the act hereby authorized:

_____________________________ _________________________ ____________________
Authorized Person Relationship to patient Phone Number
Emergency Contact

Providers (Other doctors):

____________________________ ____________________________________
Name Phone number

_____________________________ _____________________________________
Name Phone number

_______________________________________ ____________________________
Signature of patient/Guardian Date

I authorize Nelson Dermatology PLLC to leave a voicemail message at the following phone number(s):

1)________________________ 2)___________________________

Messages may at times include some protected health information, including appointment reminders, test results, instructions and any billing concerns. I understand that with my signature I am authorizing the release of oral communication by Nelson Dermatology PLLC to this voicemail number(s) and thereby release Nelson Dermatology PLLC and their staff from all legal responsibility that may arise from the act hereby authorized.

____ ________________________
Signature of patient/Guardian Date

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		

WOMEN ONLY

Date of last menstruation:		
Period every _____ days		
Are you pregnant or breastfeeding?	☐ *Yes*	☐ *No*

PLEASE CHECK THE FOLLOWING THAT PERTAINS TO YOU!!!

Check if you have, or have had, any symptoms in the following areas to a significant degree

☐ Cold sore/ Fever Blister	☐ Peptic Ulcer disease (heartburn)	☐ Stroke/ Epilepsy
☐ High Blood Pressure	☐ Pacemaker	☐ Psychiatric Condition
☐ Cataracts	☐ Type II Diabetes/ pre Diabetes	☐ Prolonger Bleeding
☐ Allergies/ Seasonal,Hives	☐ Muscular problems	☐ Cancer (breast, Colon, Lung)
☐ Glaucoma	☐ Osteo- Arthritis	☐ Kidney Disease Liver Disease (Hepatitis)
☐ Asthma- COPD- Bronchitis	☐ Joint Replacement	

Patient MEDICAL History Form

Today's Date: ____ /____ / ____

PATIENT NAME: ____DOB: ____________________

Race/Ethnicity: * mandatory data collection for all health care providers as of 2012 ask staff for handout if more information is desired

(Circle One or More)

White/Caucasian-------------African-American/Black------------Hispanic/Latino-------------

Asian----------Native Hawaiian or Pacific Islander-------------- Other: ____________________

Vitals: Estimated Weight:_______________lbs Estimated Height: _________________

1. Name of your primary care doctor? _________________________________ Dr's. Phone#_________________

2. Preferred Pharmacy Name and _____________________Pharmacy Phone #___________________________

3. What is the reason for you visit today?____

   When did the problem begin? ____

   What **body locations** are involved? ____

   Is the rash/eruption changing? (Please circle) Better ------------------Worse---------------------- Same

   Is it associated with any of the following? (Please circle) Bleeding----- Itching ------- Pain

   Have you been evaluated by another physician for this problem? (Please circle) Yes ---- No

   Any treatment used so far and response? ____

4. Female ACNE patients: Are your menstrual cycles regular? Yes / No Is the acne worse with menses? Yes / No

5. Regarding moles or growths, any change in the following? (Please circle) Color / Size / Shape / Texture

6. Please list any **MEDICATIONS** you are currently taking. *(Include over the counter medications, vitamins, birth control pills, and herbal supplements such as ginseng, ginko biloba, Echinacea st john's wort.)*

____

____

7. Do you have any **ALLERGIES** to medications or foods? (such as penicillin, sulfa, shellfish, peanuts)

____

NELSON DERMATOLOGY, PLLC
7960 Donegan Dr Ste 217, Manassas VA 20109
Office: 703-393-6366 Fax:703-656-4777
www.NelsonSkin.net

8. Please list any prior surgical procedures or cosmetic surgery.______________________________

____

9. Do you have any history of the following? Check Yes or No (*Circle condition if applicable)*

YES	NO		YES	NO	
____	___	Cold sores/fever blisters-- HSV1	____	___	Muscular problems-- back pain-- chronic pain
____	___	High Blood Pressure	____	___	Arthritis --Osteo or Rheumatoid
____	___	Stroke, CVA, TIA	____	___	Joint Replacement--knee, hip, shoulder
____	___	Heart murmur	____	____	Psychiatric --mood or bipolar dz or anxiety
____	___	Prolonged bleeding	____	____	Epilepsy Seizure disorder
____	___	Pacemaker	____	___	Attention Deficit Disorder-- ADD or ADHD
____	___	Infections — HIV, Hepatitis B or C, MRSA	____	____	Autism
____	___	Allergy Conditions – seasonal, hives	____	____	Kidney Disease – loss of kidney
____	___	Asthma ----COPD------bronchitis	____	____	Liver disease (Hepatitis)
____	___	Peptic ulcer disease (heartburn)	____	____	Cancer (breast, colon, lung, other)
____	___	Type II Diabetes/Pre-Diabetes	____	____	Hearing Loss -- Deafness
____	___	Thyroid disorder	____	____	Intellectual Disorder --Down Syn or other
____	___	Anemia, Iron Def, Thalassemia	____	____	Difficulty with anesthesia
____	___	Do you take antibiotics prior to dental work or surgery?			
____	___	Recent Hospitalization			

10. Any **other medical conditions** not listed above? ____

____

11. Do **you** have a history of **skin cancer**? Yes / No. What kind? BCC / SCC / Melanoma /

Other: _____________

12. Has anyone in your family had skin cancer? Yes / No. What kind? BCC / SCC / Melanoma /

Other: ___________

13. Is there a family history of any of the following? (Circle all that apply) Vitiligo / Lupus / Psoriasis / Eczema

14. Do you smoke cigarettes? Yes / No. How many packs per day? ______________________________

15. Do you drink alcohol? Yes / No. How many drinks per week? _______________________________

16. Do you have any pets? Yes / No. What types? ____

17. What is your occupation? ____

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