New Patient Registration

Today's Date: _____ e-mail: _____

Patient Information

First Name _____ M.I. ____ Last Name _____

Address _____ City _____ State ____ Zip _____

Phone _____ Work _____ Cell _____

Date of Birth _____ Age ____ SSN _____

Occupation _____ Employer _____

Language ❑ English ❑ Spanish ❑ Other _____

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Other

Ethnicity ❑ Hispanic or Latino ❑ Not of Hispanic or Latino ❑ Unknown

Race ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian ❑ White ❑ Other

Primary Care Dr. _____ Primary Care Dr. Phone # _____

Pharmacy Name _____ Pharmacy Phone # _____

Insurance Information

Primary Insurance _____ Referral required? ❑ No ❑ Ye s

ID# _____ Group# _____

Policyholder Name _____ Date of Birth _____

Secondary Insurance _____

ID# _____ Group# _____

Policyholder Name _____ Date of Birth _____

SunWise Dermatology & Surgery, LLC
102 Sleepy Hollow Dr. Suite No. 203, Middletown DE 19709 | (302)364-2000

Guarantor Information
(Required - fill this box if the patient is a minor)

First Name _____ MI _____ Last Name _____

Date of Birth _____ SSN _____

Phone _____ Work _____ Cell _____

Employer _____

I consent to be treated by Dr. Jennifer LaRusso DO & other healthcare practitioners providing service at SunWise Dermatology & Surgery. I understand that I am responsible for and any all charges (or amounts based on payment arrangements agreed to by them) that are included during my treatment and not paid or otherwise satisfied by my insurance benefits or other third party benefits. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I assign and request payment of authorized Medicare benefits to SUNWISE DERMATOLOGY & SURGERY, LLC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits of related services. I consent to the use and disclosure of my health information for treatment, payment & healthcare operations purposes as described in SunWise Dermatology & Surgery Notice of Privacy Practices.

Signature _____ Date _____

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FAMILY DERMATOLOGY & SURGERY

History & Intake Form

Please Check All That Apply

Patient Name: _____

Past Medical History

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplant
- ❑ BPH
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV / AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lyphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizure
- ❑ Stroke
- ❑ NONE
- ❑ Other

_____
_____
_____
_____
_____

Past Surgical History

- ❑ Appendix (Appendectomy)
- ❑ Bladder (Cystectomy)
- ❑ Breast: Breast Biopsy
- ❑ Breast:Lumpectomy (Right, Left, Both)
- ❑ Breast:Mastectomy (Right, Left, Both)
- ❑ Colon (Colectomy) Colon Cancer Resection
- ❑ Colon (Colectomy) Diverticulitis
- ❑ Colon: Inflammatory Bowel Disease
- ❑ Colon: Colostomy
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart: Coronary Artery Bypass Surgery
- ❑ Heart: Heart Transplant
- ❑ Heart: Mechanical Valve Replacement
- ❑ Heart: PTCA
- ❑ Joint Replacement: Hip (Right, Left, Both)
- ❑ Joint Replacement: Knee (Right, Left, Both)
- ❑ Kidney: Kidney Biopsy
- ❑ Kidney: Kidney Stone Removal
- ❑ Kidney: Kidney Transplant
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries (Oophorectomy) Endometriosis
- ❑ Ovaries (Oophorectomy) Ovarian Cancer
- ❑ Ovaries: Tubal Ligation
- ❑ Prostate: Prostate Biopsy
- ❑ Prostate: Prostate Cancer
- ❑ Prostate: TURP
- ❑ Rectum: APR
- ❑ Skin: Basal Cell Carcinoma
- ❑ Skin: Squamous Cell Carcinoma
- ❑ Skin: Melanoma
- ❑ Skin: Skin Biopsy
- ❑ Testicles (Orchiectomy)
- ❑ Uterus: Fibroids
- ❑ Uterus: Uterine Cancer
- ❑ Uterus: Cervical Cancer
- ❑ NONE
- ❑ Other _____

Skin Disease History		
❑ Acne	❑ Eczema	❑ Precancerous Moles
❑ Actinic Keratoses	❑ Flaking or Itching Scalp	❑ Psoriasis
❑ Basal Cell Carcinoma	❑ Hay Fever / Allergies	❑ Squamous Cell Skin Cancer
❑ Blistering sunburns	❑ Melanoma	❑ NONE
❑ Dry Skin	❑ Poison Ivy	❑ Other _____

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

Family history of Melanoma? ____ Yes ____ No

Alerts		
❑ HIV Positive	❑ Defibrillator	❑ Allergy to Lidocaine
❑ Latex Allergy	❑ History of MRSA	❑ Yeast infections with antibiotics
❑ Pregnant or planning a pregnancy	❑ Allergic to sulfa drugs or creams	❑ GI upset with antibiotics
❑ Breastfeeding	❑ Allergies to adhesives	❑ Active / History of Hepatitis
❑ Become faint or dizzy with surgical procedures	❑ Allergies to topical antibiotics	❑ West Africa: Travel or contact
❑ Blood Thinners	❑ Rapid heartbeat with Epinephrine	❑ NONE
❑ Pacemaker		

Medications: List all current medications

_____
_____
_____
_____

Allergies: List all allergies and reactions if known

_____
_____
_____
_____

Smoking Status	**Alcohol Intake**	**Exercise Frequency**	**Caffeine Use**
❑ Daily Smoker	❑ None	❑ Unspecified	❑ Unspecified
❑ Someday Smoker	❑ 1 or less per day	❑ Several times daily	❑ Several times daily
❑ Former Smoker	❑ 1-2 per day	❑ Once a day	❑ Once a day
❑ Never Smoker	❑ 3 or more per day	❑ A few times a week	❑ A few times a week
❑ Unknown		❑ A few times a month	❑ A few times a month
Start Smoking (year) _____	**Driving Status**	❑ Never	❑ Never
Quit Smoking (year) _____	❑ Daytime	❑ Other	❑ Other
	❑ Nighttime		

SUNWISE
FAMILY DERMATOLOGY & SURGERY

102 Sleepy Hollow Drive, St. 203
Middletown, De 19709

Patient Name (Print) _____ DOB_____

Legal Guardian Name _____

Authorizations

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to SunWise Dermatology & Surgery, LLC. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patients and to avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa, MasterCard, Discover, or American Express. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and copayments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

_____ _____
Patient or Legal Guardian Signature Today's Date

Medicare Health Insurance Form

I request that payment of authorized Medicare benefits be made either to me or my behalf to SunWise Dermatology & Surgery, LLC for any services furnished to me by SunWise Dermatology & Surgery, LLC. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____ _____
Patient or Legal Guardian Signature Today's Date

Medical information may be released to_____ Relationship_____
Phone_____

SUNWISE
FAMILY DERMATOLOGY & SURGERY

Cancellation Policy

We at SunWise Dermatology & Surgery, are committed to meeting our patient's health care needs. Your appointment is time set aside specifically for you.

When you miss, cancel or reschedule your appointment it prevents us from being able to help another patient. We understand that in some cases it may be difficult to keep an appointment and we will waive the fee for the first occurrence. Insurance does not cover missed appointments.

- **Please provide us 24 hours notice if you wish to cancel or reschedule a non-surgical appointment. If you fail to show up; or fail to notify us 24 hours before your non-surgical appointment, you will be charged a $25.00 fee.**

- **Please provide us 48 hours notice if you wish to cancel or reschedule a surgical (Mohs/excision) appointment. If you fail to show up; or fail to notify us 48 hours before your surgical (Mohs/excision) appointment, you will be charged a $50.00 fee.**

I have reviewed this document and understand that I will be financially responsibility for **ALL** missed, canceled or rescheduled appointments if I do not give sufficient notice as stated above.

_____ _____

Patient Signature Date

****

For Office Use Only:

Date POA received: _____ Employee Initials: _____ Filed in patient's chart: ____Yes ____ NO

SunWise Dermatology & Surgery Employee Initials / Date: _____

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Consent to Treat a Minor

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Responsible Party's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

The undersigned hereby requests and authorizes SunWise Dermatology & Surgery, LLC. to perform tests, procedures and render treatment to _____, a minor.
Patient Name

This authorization extends to all SunWise Dermatology & Surgery, LLC offices, doctors, physician assistants, and office staff members.

As of the date below, the undersigned states and avows to have the legal right to select and authorize health care services for the minor named above.

If applicable, under the terms and conditions of divorce, separation or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize the care should be revoked or modified in any way, the undersigned does hereby agree to notify SunWise Dermatology & Surgery, LLC as soon as possible.

_____ _____
Signature of Person Authorized to Sign for Patient Date

_____
Printed Name

_____ _____
Relationship to Patient Witness

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FAMILY DERMATOLOGY & SURGERY

102 Sleepy Hollow Drive, Ste. 203
Middletown, DE 19709

HIPPA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal obligations and private practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Office in person or at the above listed number. If you have biopsy, culture or an excision done, your information will be sent to be following facilities: Green Clinics Laboratory, Miraca, LabCorp/Dianon or Quest. Your signature below is an acknowledgement that you have received this “Notice of Privacy Practices”.

If you are signing as the patient’s Power of Attorney (POA), you MUST provide a copy of the Power of Attorney document to our office upon completion of signing this document and/or any other documents completed in our office. Otherwise, the patient MUST sign all forms in order to be treated in our facility.

Patient Name: _____

Signature: _____ Date: _____

If patient is a minor or if you are signing as the patient’s Power of Attorney (POA):

Print Name: _____ Relationship: _____

SUNWISE
FAMILY DERMATOLOGY & SURGERY

102 Sleepy Hollow Drive,Ste. 203
Middletown, DE 19709

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

PATIENT PRIVACY AND RIGHTS DISCLOSURE

SunWise Family Dermatology & Surgery and its employees disclose information given to us by you, your insurance company, primary care doctor and/or other medical professionals strictly for the purpose of treatment, payment of services rendered or health care operations.
We do not sell mailing lists or disclose personal information about our patients except that which is needed to carry out our objectives, which is your health.

In compliance with HIPAA guidelines, the patient understands that they have the right to review any information which is documented in the patient's record by our office and right to add an addendum to such records if recorded information is disputed.

By signing this consent, you agree to allow SunWise Family Dermatology & Surgery to use and disclose personal information about you for the reason above. You have the right to revoke this consent at anytime but must be aware that we cannot guarantee your care unless we can communicate with other health professionals when necessary.

This notice of privacy will become a part of the patient's medical record.

_____ _____

Patient Signature Date