



ACCREDITED DERMATOLOGY WELCOMES YOU!

www.accrediteddermatology.com

PATIENT INFORMATION

INSURANCE INFORMATION

PATIENT DATE OF BIRTH

First Name MI Last Name

Home Address

City, State, Zip Social Security #

Home Telephone : Cell:

Gender: Male Female EMAIL:

Marital Status: Single Married Divorced Widowed Other

Spouse's Name: Telephone:

Emergency Contact: Telephone:

Primary Care Physician: Telephone:

Name of Employer:

Work Telephone:

I hereby authorize payment directly to Accredited Dermatology for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid or not by insurance, and for all services rendered on my behalf or my dependents.

I authorize the doctor and/or any provider or supplier of service in this office to release information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that referrals are my responsibility and that I agree that I will be responsible for any balance in the absence of a valid referral.

X SIGNATURE OF RESPONSIBLE PARTY DATE

PRIMARY INSURANCE

Insurance Company:

Insurance Address:

Insurance ID#: Group#: (Insured)

Guarantor's Name: DOB:

Guarantor's Address:

Guarantor's SS#: Telephone#:

Relationship to patient: Self Spouse Child Other

SECONDARY INSURANCE

Insurance Company:

Insurance Address:

Insurance ID#: Group#: (Insured)

Guarantor's Name: DOB:

Guarantor's Address:

Guarantor's SS#: Telephone#:

Relationship to patient: Self Spouse Child Other

HOW DID YOU HEAR ABOUT US?

- INTERNET YELLOW PAGES YELLOW BOOK DOCTOR ADVERTISEMENT PATIENT REFERRAL NEWSPAPER INSURANCE BOOK / WEBSITE

Name of Source:

NAME: _____ DATE OF BIRTH: _____ CHART #: _____

WHAT IS THE REASON FOR TODAY'S VISIT? _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

ARE YOU CURRENTLY UNDER MEDICAL TREATMENT? _____ PLEASE DESCRIBE _____

HAVE YOU EVER HAD ANY SERIOUS ILLNESSES OR OPERATIONS? _____ PLEASE DESCRIBE _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? _____

NAME OF YOUR PHARMACY _____ ADDRESS & PHONE _____

NAME OF PRIMARY CARE PHYSICIAN: _____ TELEPHONE# : _____

EMERGENCY CONTACT: _____ TELEPHONE# : _____

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING?

IMPORTANT

YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/> LOCAL ANESTHETICS (EG. NOVOCAINE)	<input type="checkbox"/>	<input type="checkbox"/> BARBITURATES	<input type="checkbox"/>	<input type="checkbox"/> ASPIRIN
<input type="checkbox"/>	<input type="checkbox"/> EPINEPHRINE	<input type="checkbox"/>	(SLEEPING PILLS)	<input type="checkbox"/>	<input type="checkbox"/> LATEX
<input type="checkbox"/>	<input type="checkbox"/> PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/> NARCOTICS	<input type="checkbox"/>	<input type="checkbox"/> OTHER
<input type="checkbox"/>	<input type="checkbox"/> SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/> IODINE		(PLEASE DESCRIBE)

HAVE YOU EVER HAD THE FOLLOWING?

YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/> ANEMIA (LOW BLOOD COUNT)	<input type="checkbox"/>	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/> POLIO
<input type="checkbox"/>	<input type="checkbox"/> ANOREXIA (NO APPETITE)	<input type="checkbox"/>	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/> PROSTRATE PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/> PSYCHIATRIC CARE
<input type="checkbox"/>	<input type="checkbox"/> ASTHMA	<input type="checkbox"/>	<input type="checkbox"/> HEPATITIS - TYPE _____	<input type="checkbox"/>	<input type="checkbox"/> RESPIRATORY DISEASE
<input type="checkbox"/>	<input type="checkbox"/> BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/> HERNIA	<input type="checkbox"/>	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/>	<input type="checkbox"/> BLEEDING TENDENCY	<input type="checkbox"/>	<input type="checkbox"/> HERPES	<input type="checkbox"/>	<input type="checkbox"/> SHORTNESS OF BREATH
<input type="checkbox"/>	<input type="checkbox"/> BLOOD DISEASE	<input type="checkbox"/>	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/> SINUS TROUBLE
<input type="checkbox"/>	<input type="checkbox"/> CANCER	<input type="checkbox"/>	<input type="checkbox"/> HIV AIDS	<input type="checkbox"/>	<input type="checkbox"/> SKIN RASH
<input type="checkbox"/>	<input type="checkbox"/> CHEMICAL DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/> JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/> STROKE
<input type="checkbox"/>	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/>	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/> THYROID PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/>	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/> TONSILLITIS
<input type="checkbox"/>	<input type="checkbox"/> CHRONIC FATIGUE SYNDROME	<input type="checkbox"/>	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/>	<input type="checkbox"/> CIRCULATORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/> MEASLES	<input type="checkbox"/>	<input type="checkbox"/> ULCER
<input type="checkbox"/>	<input type="checkbox"/> CONGENITAL HEART LESIONS	<input type="checkbox"/>	<input type="checkbox"/> MIGRAINE HEADACHES	<input type="checkbox"/>	<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/>	<input type="checkbox"/> COUGH - PERSISTENT OR BLOODY	<input type="checkbox"/>	<input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/> ANY OTHER CONDITION
<input type="checkbox"/>	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/> MUMPS		_____
<input type="checkbox"/>	<input type="checkbox"/> DIABETES	<input type="checkbox"/>	<input type="checkbox"/> MULTIPLE SCLEROSIS		_____
<input type="checkbox"/>	<input type="checkbox"/> EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/> PNEUMONIA		_____

I understand that the practice of medicine is not an exact science and that outcomes cannot be guaranteed or assured. I realize that there are far too many variables that can affect the outcome of my treatment. I understand that all treatment rendered are accepted standards of care for the condition for which I have presented; however I understand that my provider makes no guarantee (express or implied) that these measures will result in a positive outcome. I agree to hold harmless Accredited Dermatology as its employees from legal action or any liability, costs, or fees arising out of any claims.

It is further understood that any biopsy taken by this practice may be sent to either IMAR Lab, and/or Dianon Labs for additional staining or second opinion. I realize the importance of ensuring a definitive diagnosis and treatment. It is understood that additional charges may be added to my account or that I may be billed an additional fee should a higher level of testing be required.

I HAVE READ AND ACKNOWLEDGED ABOVE: X _____ **DATED:** _____



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**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I hereby give consent for Accredited Dermatology to use and disclose protected health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) Accredited Dermatology's Notice of Privacy Practices provides a more complete description of Accredited Dermatology such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Accredited Dermatology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Accredited Dermatology Privacy Officer
P. O. Box 4979
Toms River, NJ 08754-4979

With this consent, Accredited Dermatology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Accredited dermatology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, test results. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Accredited Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Accredited Dermatology may decline to provide treatment to me.

Patient's Name

Print Name of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Date

November 22, 2010

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