

Rockingham Dermatology, PC

REGISTRATION FORM

PATIENT INFORMATION

<input type="checkbox"/> Mr <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Ms Patient Name: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address: _____		City: _____	State: _____
Social Security No: _____	Date of Birth: _____	Home Number: _____	<input type="checkbox"/> List all numbers then
		Cell: _____	<input type="checkbox"/> check box for preferred
		Work: _____	<input type="checkbox"/> contact number

May we leave test results or prescription information on your voicemail? YES NO

Patient Portal: List your email address if you would like access to our portal to view a summary of your health record.

Email: _____

Primary Care Physician & Location: _____		Who referred you to our office: _____	
Race: <input type="checkbox"/> Caucasian/White <input type="checkbox"/> African American/Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Other _____ Language: _____	
		Employer: _____	
		Occupation: _____	
		Retired: _____	
		If Student, Name of School: _____	

RESPONSIBLE PARTY

Name of person responsible for bill: Self (If self, skip this section) Spouse Parent / Guardian

Address (if different): _____		Date of Birth: _____
Home Number: _____	Cell: _____	Work: _____

INSURANCE INFORMATION

Primary Insurance Company: _____	Policy / ID #: _____
Name of Policy Holder/Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Insured Date of Birth: _____
Secondary Insurance Company: _____	Policy / ID #: _____
Name of Policy Holder/Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Insured Date of Birth: _____

RELEASE OF INFORMATION

With whom may we discuss your medical / financial information: (Spouse, parent, etc.)

Name: _____	Phone #: _____
Name: _____	Phone #: _____
Emergency Contact: <input type="checkbox"/> Same as Above	Phone #: _____

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I authorize Dr. Miller to provide medical care/treatment and to bill my insurance carrier for services provided. I understand and agree that I am responsible for the balance on my account for services rendered. I authorize the release of information necessary to process my claim and authorize all payments be made directly to Rockingham Dermatology.

Patient/Guardian Signature _____ Date _____

Read and Sign Back Page

Rockingham Dermatology, PC

Dr. Carolyn Miller

2061 Evelyn Byrd Ave, Ste C

Harrisonburg, VA 22801

Phone: (540) 442-8056 Fax: (540) 442-8022

Practice Policy / Financial Agreement / Notice of Privacy Practices

We are committed to providing the best possible treatment to our patients. As a courtesy, we will bill your insurance carrier on your behalf or assist you by providing copies of statements and medical documentation required for you to bill the insurance carrier directly. We understand the high cost of health insurance and we strive to help you receive the benefits to which you are entitled. If you have questions please do not hesitate to ask us. We are here to help you.

INSURANCE

While we do participate with many plans, it is not possible for our staff to be aware of each plan's specific requirements and cannot guarantee coverage to any individual. Your insurance coverage is a contract between you, your employer and the insurance carrier. We are not a party to that contract. Not all services are covered benefits. Some insurance companies select certain services they will not cover. It is your responsibility to understand and comply with any predetermined benefits or referral requirements.

PAYMENTS / COLLECTIONS

Payment for copay, account balance, Self-Pay or elective/non-covered procedures will be due at the time of service. We realize financial problems may affect timely payment of your account balance. If such problems arise please contact our office to discuss payment plan options. All accounts over 60 days past due are turned over to our collection agency. If your account is turned over for collection, you will be responsible for all collection service fees, interest and all legal fees associated with collecting the account, including but not limited to attorney fees and all court costs.

NOTICE OF DISCHARGE

Our staff works hard at preventing a patient from being discharged, there may be instances where we have no other choice but to terminate the patient and physician relationship. Reasons for discharge include, but not limited to:

- **Misconduct:** Verbal or physical abuse by patient and/or family member, causing safety concerns for staff and/or other patients. Including improper language, threats of harm, violent behavior or anger will not be tolerated.
- **Noncompliance:** Does not or will not follow the treatment plan, repeatedly cancels appointments or No Shows for scheduled appointments.
- **Nonpayment:** If your account is continuously delinquent or you do not return our calls to discuss payment options. In the event your account is transferred to our collections agency, care may not be received until the balance is paid in full.

ACKNOWLEDGEMENT STATEMENT

I understand and agree that I am responsible for my account balance for services rendered to me. With my consent, Rockingham Dermatology, may use and disclose my protected health information (PHI) for treatment, payment and healthcare operations (TPO). I received a copy of the Notice of Privacy Practices, explaining how my health information will be handled, and all my questions have been answered.

Patient/Guarantor Signature

Print Patient Name

Date

Thank you for choosing our office for your care!

Medical History

Patient: _____ **Date of Birth:** _____ **Reason for Visit:** _____

Past Medical History (Check all that apply)					
Condition		Details	Condition		Details
<i>No Past Medical History</i>	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>	
AIDS / HIV	<input type="checkbox"/>		Hives	<input type="checkbox"/>	
Alzheimer's	<input type="checkbox"/>		Joint Replacement (Within 2 years)	<input type="checkbox"/>	Year -
Anemia	<input type="checkbox"/>		Numbness	<input type="checkbox"/>	
Anxiety / Depression	<input type="checkbox"/>		Pacemaker / Implanted Electrical Devices (Please list year)	<input type="checkbox"/>	Year -
Asthma	<input type="checkbox"/>		Parkinson's	<input type="checkbox"/>	
Autoimmune Disease: Colitis, Crohn's, Lupus, Reynaud's, Ulcer's, etc.	<input type="checkbox"/>		Polycystic Ovarian Disease / Unwanted Facial Hair (Female Only)	<input type="checkbox"/>	Year -
Bleeding Disorder	<input type="checkbox"/>		Psoriasis	<input type="checkbox"/>	
Chemotherapy	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>		Sarcoidosis	<input type="checkbox"/>	
Dialysis	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>		Thyroid Disorder	<input type="checkbox"/>	
Heart Conditions - List Type	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	
Hepatitis (A, B, C)	<input type="checkbox"/>		Other Conditions:	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>				

Female Patients: Are you pregnant? Yes _____ No _____

Past Surgeries		
Date	Surgery	Complications

Has a doctor advised that you require an antibiotic prior to a procedure? Yes _____ No _____

Skin Cancer History			
Condition		Previous Treatment	Treating Physician
No Significant History	<input type="checkbox"/>		
Actinic Keratosis	<input type="checkbox"/>		
Basal Cell Carcinoma	<input type="checkbox"/>		
Malignant Melanoma	<input type="checkbox"/>		
Squamous Cell Carcinoma	<input type="checkbox"/>		
Other Lesion	<input type="checkbox"/>		

** Please complete back of this form **

Family History (Parents, Siblings, Children)			
Condition		Affected Family Member	Type
<i>No Contributing Family History</i>	<input type="checkbox"/>		
Autoimmune Diseases	<input type="checkbox"/>		
Eczema / Hayfever / Psoriasis	<input type="checkbox"/>		
Malignant Melanoma	<input type="checkbox"/>		
Skin Disease	<input type="checkbox"/>		
Thyroid Disease	<input type="checkbox"/>		

Medication Allergies		
Medication	Reaction	Notes

Current Medications

Preferred Pharmacy Name and Location: _____

Social History
Do you Smoke? No _____ Yes _____ Former smoker? No _____ Yes _____
Do you use smokeless tobacco? No _____ Yes _____
Do you consume alcohol? No _____ Yes _____ How often? Daily _____ Socially _____
Have you ever had or been treated for a Sexually Transmitted Disease? No _____ Yes _____
Do you use Illegal or Recreational Drugs? No _____ Yes _____