



**PATIENT REGISTRATION FORM**

*(Please present insurance/government issued photo ID card to receptionist)*

**Patient Name:** \_\_\_\_\_  
*First Middle Last*

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home ( )** \_\_\_\_\_ **Work ( )** \_\_\_\_\_ **Cell ( )** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **D.O.B.** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Place of Birth (City & State)** \_\_\_\_\_ **Email:** \_\_\_\_\_

<b>SEX:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>RACE:</b>	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other <input type="checkbox"/> White <input type="checkbox"/> Declined
<b>ETHNICITY:</b>	<input type="checkbox"/> Hispanic-Latino <input type="checkbox"/> Not Hispanic-Latino <input type="checkbox"/> Other <input type="checkbox"/> Declined
<b>MARITAL STATUS:</b>	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed

**Language:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_ **Phone or Zip Code:** \_\_\_\_\_

**RESPONSIBLE PARTY NAME AND ADDRESS (if other than the patient)**

**Name:** \_\_\_\_\_ **Social Sec. #:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**D.O.B.** \_\_\_\_/\_\_\_\_/\_\_\_\_

**The following section applies if you are NOT the policy holder**

**Primary Insurance Name:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **D.O.B.** \_\_\_\_/\_\_\_\_/\_\_\_\_

**I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. Please Check:**  Medicare  Medicaid  Private Insurance

**X**  
\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date



THE DERMATOLOGY CLINIC  
OF ARKANSAS

## FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office.

Payment is required in full for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payment and deductibles will be collected.

Any unpaid balance, after insurance payment, is due from the patient. Since our relationship is with the patient, the bill is the patient's responsibility. The patient will receive a monthly statement any time there is a balance on the patient's account that is considered patient responsibility. **If the entire balance cannot be paid in full, our business office can arrange a payment plan for the patient.**

Co-pays are due at the time of treatment. These amounts vary depending upon which managed health care plan the patient may have.

Payments Accepted: **Cash, Check, VISA, MasterCard, Discover, or American Express**

There is a \$25.00 charge to the patient for returned checks due to insufficient funds or closed accounts.

We accept Medicare assignment and participate in a number of HMO's, PPO's and other managed care plans. We must have a copy of the patient's insurance card and all insured party information including date of birth and social security number to process the claim.

Financing options are available through  Please inquire at checkout.

## MEDICAL RECORDS

Patient fee for copying of records is \$.50 per page for the first 25 pages, and \$.25 per page thereafter. Please review your Explanation of Benefits from your insurance carrier.

If you have any questions or feel you are due a refund from The Dermatology Clinic, please contact our billing office at (501) 623-3400. We are always willing to be of assistance to you.

Your signature below signifies your understanding and willingness to comply with this policy.

X  
\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



THE DERMATOLOGY CLINIC  
OF ARKANSAS

## HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

Your signature consents to use and disclosure of your protected health information for treatment, payment & health care operations. You have the right to revoke this Consent, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Dermatology Clinic is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations;
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice;
- The Practice reserves the right to change the Notice of Privacy Policies;
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions;
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease;
- The Practice may condition treatment upon the execution of this Consent;
- The Practice has an updated Notice of Privacy Practices.

Patient was offered the HIPAA Notice of Privacy Form:  Accepted  Refused

### Do we have your permission to?

Leave a message on your home answering machine?  Yes  No  N/A

Leave a message at your place of employment?  Yes  No  N/A

Discuss your medical condition with any member of your household?  Yes  No  N/A

(If yes, with whom: \_\_\_\_\_ Relationship: \_\_\_\_\_)

**X** \_\_\_\_\_  
Patient / Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

Witnessed By: \_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)



## HISTORY AND INTAKE FORM

### Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Hypercholesterolemia
Arthritis	Depression	Hyperthyroidism
Asthma	Diabetes	Leukemia
Atrial fibrillation	End Stage Renal Disease	Lung Cancer
Bone Marrow Transplantation	GERD (Acid Reflux)	Lymphoma
BPH (Benign Prostatic Hyperplasia)	Hearing Loss	Pacemaker
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	Hypertension	Radiation Treatment
COPD (Emphysema)	High Blood pressure	Seizures
Coronary Artery Disease	HIV/AIDS	Stroke
		Valve Replacement
Other		

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### Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Transplant
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Liver Removed
Lumpectomy (Right, Left, Bilateral)	Liver Transplant
Breast Biopsy (Right, Left, Bilateral)	Liver Shunt
Breast Implants	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Ovaries Removed: Cyst
Colectomy: Diverticulitis	Tubal Ligation
Colectomy: IBD	Pancreas Removed
Colon: Colostomy	Prostate Biopsy
Gallbladder Removed	Prostate Removed: Prostate Cancer
Biological Valve Replacement	TURP (Prostate Removal)
Coronary Artery Bypass	Rectum: APR
Heart Transplant	Rectum: Low Anterior Resection
Mechanical Valve Replacement	Skin: Basal Cell Carcinoma
PTCA	Skin: Melanoma
Joint Replacement, Hip (Right, Left, Bilateral)	Skin: Squamous Cell Carcinoma
Joint Replacement, Knee (Right, Left, Bilateral)	Spleen Removed
Kidney Biopsy	Testicles Removed (Right, Left, Bilateral)
Kidney Stone Removal	Hysterectomy: Fibroids



**Skin Disease History:** (please circle all that apply)

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer

Other: \_\_\_\_\_

Do you wear Sunscreen?       Yes    No    If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?       Yes    No

Do you have a family history of Melanoma?       Yes    No

If yes, which relative(s)? \_\_\_\_\_

**Medications:** (Please enter all current medications, dosage and how often it is taken)

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**Allergies:** (Please enter all **MEDICATION** allergies)

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THE DERMATOLOGY CLINIC  
OF ARKANSAS

**Social History (please circle one)**

**Cigarette Smoking:**

Currently Smokes  
Never smoked  
Former Smoker

**Language:**

English  
Spanish  
Other: \_\_\_\_\_

**Ethnicity:**

Hispanic/Latino  
Non-Hispanic/Latino

**Alcohol Use:**

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

**Race:**

White  
Black/African American  
American Indian or Native Alaskan  
Other: \_\_\_\_\_

**Driving Status:**

Drives in the Daytime  
Drives at Night

**How Often do you exercise?**

Once a day  
A few times a week  
A few times a month  
Never

**Caffeine use**

Once a day  
A few times a week  
A few times a month  
Never

Occupation and Workplace: \_\_\_\_\_

Residence / Facility: \_\_\_\_\_



THE DERMATOLOGY CLINIC  
OF ARKANSAS

**REVIEW OF SYSTEMS**  
New / Referred Patient

Problems with Healing	Yes	No
Problems with Scarring	Yes	No
Rash	Yes	No
Photosensitivity	Yes	No
Nodules / Other Types of Lesions	Yes	No
Fever Blisters / Oral Herpes Infections	Yes	No
Genital Lesions	Yes	No
History of Shingles	Yes	No
Problems with Bleeding	Yes	No
Swollen / Tender Lymph Nodes	Yes	No
Immunosuppression	Yes	No
Hay Fever	Yes	No
Chest Pain	Yes	No
Palpitations	Yes	No
Fever or Chills	Yes	No
Frequent Infections	Yes	No
Fatigue / Malaise	Yes	No
Night Sweats	Yes	No
Unintentional Weight Loss	Yes	No
Unintentional Weight Gain	Yes	No
Thyroid Problems	Yes	No
Blurry Vision	Yes	No
Abdominal Pain	Yes	No
Nausea / Vomiting	Yes	No
Constipation / Diarrhea	Yes	No
Bloody Stool	Yes	No
Bloody Urine	Yes	No
Menopause	Yes	No
Joint Aches	Yes	No
Muscle Weakness	Yes	No
Neck Stiffness	Yes	No
Arthritis	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Cough	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Insomnia	Yes	No
Sore Throat	Yes	No
Thrush	Yes	No



**REVIEW OF SYSTEMS**  
New / Referred Patient

Blood Thinners	<b>Yes</b>	<b>No</b>
Aspirin	<b>Yes</b>	<b>No</b>
Pacemaker	<b>Yes</b>	<b>No</b>
Defibrillator	<b>Yes</b>	<b>No</b>
Artificial Heart Valve Within Last Two Years	<b>Yes</b>	<b>No</b>
Rapid Heartbeat with Epinephrine	<b>Yes</b>	<b>No</b>
Allergy to Lidocaine	<b>Yes</b>	<b>No</b>
Allergy to Adhesive	<b>Yes</b>	<b>No</b>
Allergy to Latex	<b>Yes</b>	<b>No</b>
Allergy to Topical Antibiotic Ointment	<b>Yes</b>	<b>No</b>
Premedication's Prior to Procedures	<b>Yes</b>	<b>No</b>
Pregnancy or Planning a Pregnancy	<b>Yes</b>	<b>No</b>
MRSA	<b>Yes</b>	<b>No</b>
HIV	<b>Yes</b>	<b>No</b>
Hepatitis	<b>Yes</b>	<b>No</b>

X \_\_\_\_\_  
Patient Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
D.O.B.