



## PATIENT REGISTRATION FORM

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Name: \_\_\_\_\_ ☐ Jr. ☐ Sr.  
First Middle Last

Prefer to be called: \_\_\_\_\_ Gender(Sex): M ☐ F ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐

Race : White ☐ Black ☐ Asian ☐ Indian ☐ Other ☐ Declined to Provide ☐

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Language Spoken (Idioma): \_\_\_\_\_

Address: \_\_\_\_\_  
Street# Street Name Apt.#  
City State Zip Code

Employer: \_\_\_\_\_  
Name Address

Home ☎: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Month Day Year

Work ☎: \_\_\_\_\_ Cell. ☎: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Policy Owner S.S. # \_\_\_\_\_

Where should statement of your account be sent if different from above?

Name Address Apt.# State Zip

Primary Doctor: \_\_\_\_\_ ☎: \_\_\_\_\_

Who referred you? \_\_\_\_\_

In case of Emergency contact: \_\_\_\_\_ ☎: \_\_\_\_\_

Relationship \_\_\_\_\_ Your E-mail: \_\_\_\_\_

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF THE SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Policy owner if other than patient

Patient relationship to Policy owner: ☐ Self ☐ Child ☐ Other: \_\_\_\_\_

## DERMATOLOGY MEDICAL HISTORY

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Patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications? ☐ YES ☐ NO if yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine or other)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over -the-counter meds..., vitamins and herbal):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

<b>Lungs:</b> .....	YES	NO	<b>Other Systemic:</b> .....	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b> .....	YES	NO	Nausea, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pacemaker</b>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
			Artificial Valves or a Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

### Skin:

Have you ever had skin cancer?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has anyone in your family had skin cancer?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a history of any specific skin diseases?	<input type="checkbox"/> YES	<input type="checkbox"/> NO if yes, _____
Do you have problems with healing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you develop keloids (scars) after surgery?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you bleed easily?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you develop skin rashes in reaction to	<input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Environment? _____	

### Social History:

Do you drink alcohol?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	if YES _____ drinks per day
Do you use IV drugs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	if YES, what? _____ How often? _____
Do you smoke?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	if YES, how much: _____

Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

Please answer the following questions:

(Women) Are you pregnant? ☐ YES ☐ NO Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you planning to get pregnant in the near future? ☐ YES ☐ NO

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by: ☐ Patient  
☐ Medical Assistant \_\_\_\_\_

Signed By Patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT CONSENT FORM

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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.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply 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 Practices
- 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 receipt of treatment upon the execution of this Consent.

### **DO WE HAVE YOUR PERMISSION TO:**

- **LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME  
(INCLUDING REMINDERS FOR APPOINTMENTS)?** YES\_\_\_ NO\_\_\_
- **LEAVE A MESSAGE ON YOUR PLACE OF EMPLOYMENT?** YES\_\_\_ NO\_\_\_
- **LEAVE A MESSAGE ON YOUR CELLULAR PHONE?** YES\_\_\_ NO\_\_\_
- **DISCUSS YOUR MEDICAL CONDITION WITH ANY OTHER  
MEMBER OF YOUR HOUSEHOLD?** YES\_\_\_ NO\_\_\_

**IF YES, WHOM:** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_

Please give any additional comments in reference to the release of your medical condition(s) or appointments.

\_\_\_\_\_  
\_\_\_\_\_

### **This Consent was signed by:**

\_\_\_\_\_  
Printed Name - Patient or Representative

Relationship to Patient (if other than patient): \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_

## **HOLLYWOOD DERMATOLOGY POLICY CONSENT FORM**

**The following is to advise you of our office policies. Some policies listed below may not pertain to your specific treatment but may for future procedures and/or treatments. Please review and sign below.**

Minors under the age of 18 must be seen, at the time of their appointment, with their parent, legal guardian or an authorized adult. A note must be accompanied with the authorized adult, signed by the patient's parent, giving full authorization to that adult. Minors under the age of 18 will not be seen if not accompanied by an adult.

**Treatment Fees:** Treatment fees are estimates and could change depending on your treatment plan needs.

**The patient is responsible for all insurance deductibles, co-pays and services subject to their insurance plan limitation and exclusions.**

**The patient is responsible for all balances due with all out-of-network insurance companies.**

**Providers with your Insurance:** It is your responsibility to know if your doctor is considered an "in-network" provider by your plan. Please contact your insurance to verify. If you have more questions with regards to your insurance plan, you may contact our billing department as well.

**Payment Options:** CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, DEBIT CARDS, MONEYORDERS, CASHIERS CHECK AND CARECREDIT (with \$300.00 minimum for care credit) are payment options accepted.

**Payment Plans:** Payment plans may be arranged with CareCredit. All balances due that do not get paid within 3 months may be referred to a Collection Agency. If you are interested, you may apply for CareCredit in our office today.

**There is a \$25.00 FEE if you fail to cancel or reschedule an appointment at least 24 hours prior.**  
Some cosmetic procedures may incur a higher cancellation/no show fee.

**All Cosmetic and Private Pay visit fees are due at the time of service.** If you cannot attend to your Cosmetic appointment, you must cancel or reschedule your appointment at least 48 hours in advance. A \$200.00 fee will be assessed to your account if you do not cancel or reschedule your Cosmetic appointment 48 hours prior.

**Cosmetic Procedures, such as Blepharoplasty, Laser Lipo, CO2 Laser, require 100% full payment before the appointment.** You may pay by major credit cards, check or CareCredit.

**Cosmetic removal of benign lesion(s):** Skin tags, age spots and normal moles are considered cosmetic procedures. Hollywood Dermatology does not bill insurance companies for cosmetic procedures since Hollywood Dermatology will not receive any payment from the carrier for services rendered.

**Prescription Refill Policy:** Our physicians prescribe their patients enough refills to last until their next follow-up appointment. We are unable to refill prescriptions by telephone. If you would like refills of any medications prescribed by one our doctors, please ask the doctor you are seeing today during your examination.

**All surgical pathology & other lab specimens are submitted to outside laboratories for processing and analysis, which may lead to an additional fee you may be charged outside of our office.**

It is your responsibility to let us know if your insurance company requires that we send your labs to a specific pathologist in order for you to receive full benefits.

**Please advise your doctor of your allergy history.** Some procedures may require the use of anesthesia, latex glove and certain medications so it is important to know your allergies ahead of time.

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

## **PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY**

**Check here if minor or unable to provide consent** \_\_\_\_\_

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact: \_\_\_\_\_ By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

**1)** I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

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

\_\_\_\_\_  
(Witness)

**2)** I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publication:

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

\_\_\_\_\_  
(Witness)

**3)** I agree to use of my image for medical records ONLY:

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

\_\_\_\_\_  
(Witness)

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlined above:

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

\_\_\_\_\_  
(Witness)