WELCOME TO DERMAblue

PATIENT REGISTRATION FORM

Patient Information:

Patient/Child First Name:______________________ MI:_________ Last Name:_____________________

Age:__________ Date of Birth:_____________________ Occupation:___________________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Widow/widower ☐ Divorced Soc. Sec. #:_________________

Mailing Address: ____

City:________________________________ State:__________ Zip Code: _______________________

Home Phone:_________________ Work Phone:_________________ Cell Phone: _________________

Email address:_____________________________ Drivers License #:____________________________

Primary Care Provider:____

Referring Doctor:____

Parent/Guardian (REQUIRED IF PATIENT IS UNDER 21 YEARS):

NOTE: Per NC Law, Both Parents can be held responsible for medical bills for minors, a medical practice is NOT bound by any separation agreement, divorce or child support order.

Parent/Guardian:______________________________________ Birth Date:_______________________

Address (if different from above):____

Social Security # (required):_____________________________ Employer: ______________________

Preferred Phone #: __________________________

In case of an emergency, who would you like to be contacted?

Contact Name:__________________________________ Relationship to Patient:_________________

Home Phone #:_____________________________ Work Phone #: _____________________________

DermaBlue is a part of LaMond Family Medicine. You may notice LaMond Family Medicine on your Explanation of Benefits and/or Statement. By signing, you agree the information above is correct and give permission for DermaBlue and Lamond Family Medicine to file claims on your behalf.

HIPAA CONSENT: Without signed consent, we can NOT share information regarding your medical care (including family). Please list anyone you would like to have this information below. (leave blank if you would not like any additional individuals to have information regarding your care.

1. __________________________ Patient/Guardian Signature: ______________________________

2. __________________________ Date: ____

Please print this form to bring to your appointment, or you can email it to info@dermablue.com

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Financial Policy and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to DermaBlue and LaMond Family Medicine.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give new updated insurance information 3) Expenses not covered by insurance 4) deductible not met 5) services rendered are deemed medically unnecessary by insurance. ***Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries).***

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections and may be reported to your credit.

Returned Checks: In the event a check is returned for Non Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds. Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. We will NEVER call in ANY pain medications, antibiotics or narcotics to any drug store. If you need a prescription refill, please call your pharmacy and ask that they fax a refill request to our office. Our providers will review the request and refill the prescription by return fax or we may request you make a follow up appointment if necessary. Please allow 24 hrs for a response to refill requests. Samples are given at scheduled appointments ONLY and can ONLY be given by the doctor.

Missed Appointments: We charge $50.00 for any no show appointment not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no show" to 3 appointments within 1 year, we have the right to dismiss you from our practice for non compliance.

Patient/Guardian Signature for Financial and Office Policies: ______________________________

(Refusal to sign does NOT prevent responsibility/obligation regarding this office's financial policy).

HIPAA COMPLIANCE STATEMENT - THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager.

Signature: (HIPAA Policy) ______________________________ Date:____________

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SKIN HEALTH HISTORY

Name:______________________ Date:________________ DOB:______________

Reason for Visit:____

Description of Problem:____

Skin Medical History:

- [ ] Acne/Accutane
- [ ] Burns/Skin Grafts/Scarring
- [ ] Hemorrhoids
- [ ] Excessive Hair Growth
- [ ] Kaposi's Sarcoma
- [ ] Early Puberty
- [ ] Seizures
- [ ] Pacemaker
- [ ] Bleeding Disorders
- [ ] Diabetes
- [ ] Gold Therapy
- [ ] Hormone Replacement Therapy
- [ ] Keloid Scarring
- [ ] PCOS (Polycystic Ovary Disease)
- [ ] Psoriasis
- [ ] Shingles
- [ ] Epidermolysis Bullosa
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Lupus
- [ ] Port Wine Stain
- [ ] Rosacea
- [ ] Skin Cancer
- [ ] Vitiligo
- [ ] Filler Injections
- [ ] Permanent Makeup
- [ ] Tattoos
- [ ] Herpes/Cold Sores
- [ ] Botox
- [ ] Implants: Breast, Facial

Please answer the following medical questions:

Question	Yes	No
1. Have you ever seen a physician regarding your skin?	☐ Yes	☐ No
2. Do you have any active skin diseases or infection in the area to be treated?	☐ Yes	☐ No
3. Do you have any skin allergies?	☐ Yes	☐ No
4. Have you had skin cancer or pre cancerous lesions?	☐ Yes	☐ No
5. Do you have psoriasis/eczema in the area to be treated?	☐ Yes	☐ No
6. Are you allergic to latex, lidocaine, or any lotions?	☐ Yes	☐ No
7. Have you or are you currently using Accutane?	☐ Yes	☐ No
8. Have you had any previous laser treatments other than DermaBlue?	☐ Yes	☐ No
9. Do you use facial depilatories?	☐ Yes	☐ No
10. Are you using Retin-A, Renova, Differin, Tazorac?	☐ Yes	☐ No
11. Are you using glycolic/AHA home care products?	☐ Yes	☐ No
12. Do you use a sunscreen?	☐ Yes	☐ No
13. Does your skin remain discolored after healing from a cut?	☐ Yes	☐ No
14. Do you sunbathe/suntan or use tanning beds?	☐ Yes	☐ No

If yes, approx. date of last sun exposure: ________________

15. What skin care products are you currently using? ______________________________

Please indicate which of the following concerns you have about your skin or services you would like to learn more about:

- [ ] Aging Skin/Wrinkles
- [ ] Acne
- [ ] Redness
- [ ] Leg Veins, Facial Veins
- [ ] Sun Damage/Age Spots
- [ ] Scarring
- [ ] Enlarged Pores
- [ ] Hair Removal
- [ ] Hyperpigmentation /Skin Coloration unevenness
- [ ] Rosacea
- [ ] Cellulite/Stretch Marks
- [ ] Cosmetic Filler Treatments
- [ ] Botox
- [ ] Dry, Oily, or Sensitive Skin
- [ ] Body Contouring; Non-invasive/ Smoothshapes
- [ ] Weight Control Services
- [ ] Bioidentical Hormone Therapy

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HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Personal Health History:

Name:______________________________ Primary/Referring Physician:____________________________

Date:____________________ Height:______________ Weight:______________ Age:______________

List any medical problems that other doctors have diagnosed:

Year:	Medical Problem:	Treatment/Medication(s): *(if prescribed)*

Surgeries:

Year:	Type of Surgery:	Surgery Reason:

List your prescribed drugs, over the counter medications and supplements

Name of Drug:	Strength:	Frequency Taken:

Allergies to medications:

Name of Drug:	Reaction:

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HEALTH HABITS

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise: (check your selection) ☐ Sedentary (no exercise) ☐ Lightly active (1-3 days per week)
☐ Moderately Active (3-5 days per week) ☐ Very Active (6-7 days per week)

☐ Caffeine ☐ Coffee ☐ Tea ☐ Cola ☐ None ____ # of cups/cans per day?

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? ______________________________

How many drinks per week? ______ Are you concerned about the amount you drink ☐ Yes ☐ No

Do you Use Tobacco? ☐ Yes ☐ No Cigarettes (packs/day): _____ Chew (#/day): ________

Pipe (#/day): _____ Cigars (#/day): _____ # of years: _______ Year quit: _______________

Family Health History: (Please comment on general, weight and psychiatric history)

	Age	Significant Health Problems
Father:	______	______________________________
		______________________________
Mother:	______	______________________________
		______________________________

Children:

How many children: _____ Ages: _____ _____ _____ _____ _____ _____

	M/F	Age	Significant Health Problems
Sibling:	______	______________	______________________________
Sibling:	______	______________	______________________________
Sibling:	______	______________	______________________________
Sibling:	______	______________	______________________________

	Age	Significant Health Problems
Grandmother (Maternal):	_______	______________________________
Grandfather (Maternal):	_______	______________________________
Grandmother (Paternal):	_______	______________________________
Grandfather (Paternal):	_______	______________________________

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NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I, ________________________________, understand that as part of my health care, DermaBlue originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided,
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I have the following rights and priveleges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that DermaBlue reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the physicians at DermaBlue change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. Mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such discolsure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

______________________________________ ______________________

Patient's Signature (authorized representative signing for patient) Date

OFFICE USE ONLY [ ]: Consent received by:________________________ on ____________

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HIPAA

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Signature: ____ Date: ____________________

By signing this document, I confirm that I fully understand and accept the terms of this consent.

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