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:_____

Pharmacy and Location:_____

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.

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:_____Social Security # (required):_____

Address (if different from above):_____

Employer: _____ Preferred Phone #: _____

HIPAA CONSENT: Below, please list anyone you would like to be allowed to receive information regarding your medical care (leave blank if you would not like any additional individuals to have information regarding your care).

1. _____ 2. _____

By signing, you agree the information above is correct and give permission for DermaBlue to file claims on your behalf as well as share your medical care information with the above listed contacts. *Without signed consent, we can NOT share information regarding your medical care (including family).*

Patient/Guardian Signature: _____ Date: _____

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: _____

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:_____

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

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 Intake: _____ # of cups/cans per day? ☐ Coffee ☐ Tea ☐ Cola ☐ None

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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DERMAblue

SKIN BIOPSY/SURGERY

Patient Name:_____ Date:_____

During your visit, your provider may need to perform a skin biopsy or minor surgery to evaluate your skin condition. Please review and sign below. You will be given ample time to discuss the procedure if the provider determines a skin biopsy is necessary.

PURPOSE:

A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician/provider in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.

PROPOSED TREATMENT:

I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain inherent risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician (such as the degree of sun damage or patient compliance with post-operative instructions) affect the ultimate healing.

A pathologist will examine the tissue obtained in this biopsy procedure. I understand that I may receive a separate bill from the pathologist or laboratory for this microscopic examination.

I UNDERSTAND THE FOLLOWING MAY OCCUR AS A RESULT OF SKIN SURGERY:

1. All humans heal by permanent scar formation, thus all surgeries will result in a scar.
2. Scar tissue is pink for 3-6 months, and then usually fades to white. Sun exposure may cause a scar to darken.
3. The appearance of a surgical scar usually continues to improve for 6-12 months, as the scar "matures". The surgery scar is usually strong by 4 weeks.
4. Scars overlying active muscle areas tend to stretch or widen with time. This cannot always be prevented.
5. Scars can heal thick (keloid or hypertrophic) or heal thin (atrophic). How they heal depends partly on their location on the body and the healing process of the patient. The final appearance of a scar depends upon many factors. While we strive in every case to achieve the best cosmetic result possible, this cannot be guaranteed.
6. If a surgical site is injured before healing is complete, the scar may remain open, the wound may bleed, and the scar may become more obvious.
7. A change of feeling (sensation) often occurs around a scar. It may be numb or sensitive. In some areas of the body there is a risk of motor nerve damage.
8. Infection or bleeding can occur after surgery.
9. Serious or life threatening reactions may occur to any ointment, dressing, or medication, including local anesthetics used during surgical procedures.
10. Sometimes more than one surgical procedure is necessary to remove a large lesion, to remove a lesion in a difficult area, or to obtain the best possible cosmetic result. I understand that the excision will need to be approximately three times the width of the original lesion.
11. If any unforeseen event should occur during the course of the procedure, I authorize the provider to take whatever steps necessary to perform what ever procedure(s) deemed advisable which may be different or in addition to from that which has been planned and discussed with me. (this would cover tying off a vessel, making the incision larger for dog ears and undermining to close incision)
12. The lesion removed may be sent to an outside lab for further analysis. The lesion may recur or regrow.
13. I consent to the taking of photographs or recording of my procedure for the purpose of documentation- photos are really helpful to relocate an area if the entire lesion was removed.

I certify that I have read and understand the contents of this consent form. I have been given the opportunity to ask the provider/staff any questions that I have about the procedure, and all of my questions have been answered. The provider/staff has explained the procedure and its alternatives to me, and I both understand and accept the risks involved in this procedure. I hereby authorize my provider and his/her assistant to remove the above lesion.

Patient/Guardian:_____ Date:_____

Witness/Title:_____ Date:_____