JANE T. CHEW, M.D.
Columbia Dermatology Center

PATIENT REGISTRATION FORM

NAME_____ DATE OF BIRTH_____
First Middle Last SEX: **M** **F**
MARITAL STATUS_____
SS #:_____

ADDRESS_____
Street City State Zip

HOME #:_____ WORK #:_____ CELL #:_____

EMAIL:_____ OCCUPATION:_____ EMPLOYER:_____

How did you hear about us?_____

PRESENT YOU INSURANCE CARD (S) FOR PHOTOCOPY AND COMPLETE BELOW
If no card is available, payment in full is expected.

PRIMARY INSURANCE COMPANY
Company Name_____

Policyholder: Yourself **Y** **N** If No, complete below

Policyholder Name:_____

SEX: **M** **F** Birthdate:_____

RELATIONSHIP_____

SECONDARY INSURANCE COMPANY
Company Name_____

Policyholder: Yourself **Y** **N** If No, complete below

Policyholder Name:_____

SEX: **M** **F** Birthdate:_____

RELATIONSHIP_____

Do we have your permission to:

Leave a message on your answering machine at home or mobile phone? ____yes ____no
Leave a message at your place of employment? ____yes ____no
Discuss your medical condition with any member of your household? ____yes ____no

Pharmacy of choice _____
In case of Emergency, who should be notified?_____

PAYMENT AND INSURANCE AGREEMENT

I attest the above information is correct and will be used for billing purposes. I authorize release of medical information to my insurance company (s), primary care or referring physician and pharmacies. Further, your signature authorizes the Doctor to release medical information necessary to process your insurance claims (if any). If my insurance company does not pay, I understand that I am responsible for my bill. I understand that I am responsible for my bill. **Charges, deductibles, copays, and/or coinsurances are due at the time of service. A charge of $25.00 may be assessed for a missed appointment. Also, if we are forced to turn your account over to our collection agency, you will be responsible for all collection fees incurred. I understand that I am responsible for obtaining a referral from my primary care doctor if required by my insurance. If I fail to obtain the referral, I will be responsible for my bill.** I authorize Columbia Dermatology Center to act as my agent in helping me obtain payment from my insurance company (s). I authorized payment directly to Columbia Dermatology Center. A copy of this can be used in place of the original.

You will be given the opportunity to review our Notice of Privacy Practices. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996. Please initial to confirm this opportunity.

Signature_____ Date_____

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DERMATOLOGY MEDICAL HISTORY

To help us provide you with optimal health care, please take time to accurately complete this form and provide us with this vital information.

Name (print):_____ **Date:**_____

Reason for today's visit:_____

Are you allergic to any medications? If yes, please explain:_____

Please list all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbs):_____

_____

Social History & Habits:

Have you ever smoked?_____Have you ever used IV drugs?_____

Do you drink alcohol? _____ If yes, ___ drinks per day. Have you been exposed to HIV (AIDS)?_____

Have you been exposed to hepatitis?_____Are you pregnant?_____

Please check if you have now or have had any of the following problems:

HEART / LUNGS: Persistent cough_____ Shortness of breath_____ Asthma_____ Chest pain_____
High blood pressure_____ Heart murmur_____ Irregular heart beat_____ Blood clots_____
Inflammation of veins (phlebitis)_____ Heart attack_____ Pace maker_____

GUT / KIDNEYS: Stomach problems_____ Diabetes_____ Liver problems_____

BONES / JOINTS: Arthritis_____ Osteoporosis_____ Artificial joint replacement_____

Have you ever had a blood transfusion?_____ Have you ever fainted?_____

List any other diseases or conditions, or provide details about the above items:_____

_____

_____

_____

List any surgical procedures you have had in the past 6 months:_____

_____

Skin History:

Have you ever had skin cancer?_____

Has anyone in your family had skin cancer?_____

Do you have a history of any specific skin diseases?_____

Do you have a problem with healing?_____

Do you develop keloids or scars after surgery?_____

Do you bleed easily?_____

Have you had a bad reaction to any dental anesthesia (Novocaine)?_____

The above is true and correct to the best of my belief: _____ _____
Signature Date

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Financial Policy

We are pleased that you have selected our office to provide your Dermatologic care. As part of that care, we have developed this statement of our financial policy. Please carefully read the following, initial where indicated, and sign below.

Health Insurance Participation

_____ Initials

Columbia Dermatology participates in many, but not all health insurance plans. If we do participate with your health insurance plan, you must present a valid insurance identification card at check-in. Without a valid insurance card, or if we do not participate in your health insurance plan, you may reschedule your appointment or payment for your visit will be due today.

Co-payments

_____ Initials

Some insurance plans require payment of a Co-pay. Co-payments are due at check-in. Payments can be made by check, cash, MasterCard or VISA. Without a co-payment, you may be rescheduled.

Referrals

_____ Initials

Some insurance plans require a written referral from a primary care provider. Referrals must be presented at check-in. Having a valid referral is a patient's responsibility. It is your responsibility to know how many visits are allowed on your referral and the expiration date of your referral. Without a valid referral, you may reschedule your appointment or payment for your visit will be due today.

Financial Responsibility

_____ Initials

Patients are responsible for all co-payments, deductibles, and charges not covered by health insurance.

Account Balances

_____ Initials

All outstanding balances must be paid at time of check-in, or you must reschedule your appointment. We offer the convenience of having your credit card information securely filed to automatically cover any outstanding balances on your account. Failure to pay outstanding balances may result in the practice forwarding your account to a Collection Agency or Collection Attorney of our choice and may result in additional fees, including an administrative fee of 30%.

Rescheduling/Canceling Appointments

_____ Initials

Please help us serve you by keeping your scheduled appointments. Should you need to change your appointment, contact our office at least 24 hours prior to your originally scheduled visit. Following two consecutively missed appointments, a $25 missed appointment fee will be charged. After three consecutively missed appointments, the scheduling of future appointments would be at the discretion of your physician.

If you are more than twenty (20) minutes late for your appointment, you will be asked to reschedule your appointment.

I have read and understand the office policies explained above.

_____ _____

Patient/ Responsible Party Signature Date

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