COWAN DERMATOLOGY

PATIENT REGISTRATION FORM

Last Name: _____

First Name: _____Middle Initial: _____

Previous Name: _____

Mailing Address: _____

PO Box: _____

City: _____State: _____Zip Code: _____

Home Phone #: _____Cell Phone #: _____

Work Phone #: _____Extension: _____

FOR MINORS ONLY

Parent/Guardian Name: _____

Mailing Address: _____

City: _____State: _____Zip Code: _____

Home Phone #: _____Cell Phone #: _____

Relationship to patient: _____

SS# _____ Date of Birth: _____

Who is the policy holder for your insurance?

☐Self

☐Spouse, if so please provide the following:

Policy Holder Name: _____

Date of Birth: _____ Relationship to patient: _____

Do you have an advanced directive or surrogate decision maker that you wish our office to keep on file?

☐Yes (please provide a copy to our office) ☐No

Email Address:

_____

☐Do not have email to provide ☐Prefer not to disclose

As of 1/1/09, per Kentucky state law and the Office of Health Policy, we are required to collect the following information:

Race: ☐American Indian ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White/Caucasian ☐Hispanic ☐Other ☐Prefer not to disclose

Ethnicity: ☐Hispanic ☐Not Hispanic

Language: ☐English ☐Other: _____

How did you hear about our practice?

☐Family/Friend Name: _____ ☐Physician Name: _____

☐Insurance Provider List ☐Newspaper ☐Internet ☐Yellow Pages

Primary Care Physician: _____

Have you been referred by a physician for a specific problem?

☐ Yes ☐ No Referring Doctor: _____

Date of Birth: _____ ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Separated ☐Partner

Social Security Number: _____

Adult Emergency Contact: _____

Relationship to Patient: _____

Mailing Address: _____

City: _____

State: _____Zip Code: _____

Home Phone #: _____Cell Phone #: _____

RELEASE OF INFORMATION

Please list any person(s) to whom your protected health information may be disclosed (spouse, parent, child, etc.):

Name: _____ Relationship: _____

Home Phone #: _____Cell Phone #: _____

Name: _____ Relationship: _____

Home Phone #: _____Cell Phone #: _____

Local Pharmacy Name: _____

Location: _____

Phone: _____

(for maintenance medication only)

Mail Order Pharmacy Name: _____

- I hereby give my permission to Bowling Green Dermatology and Skin Cancer Specialists, PLLC/Glasgow Dermatology for the evaluation and treatment of the presented dermatological condition.
- I hereby authorize the above physician(s) to release information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.
- I hereby authorize the physician(s) indicated above to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign all payments for medical services rendered.
- I, the undersigned, agree that if this account is not paid when due, to reimburse the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.
- I consent to receive phone calls, emails and/or text messages at any of the phone numbers/email addresses listed above for such events as appointment reminders, reschedules, and inclement weather closings. I understand I may incur charges from my cell provider. I understand I may revoke authorization to receive further calls or messages at any time.
- I have read the policies on the reverse of this page, including the cancellation, financial, release of records and privacy policy statements for Bowling Green Dermatology and Skin Cancer Specialists, PLLC/Glasgow Dermatology and agree to the terms here in.
- I also understand that such terms may be amended when needed by the practice.

Patient or Responsible Party Signature: ✖_____Date: _____

COWAN DERMATOLOGY

POLICIES & PROCEDURES

✓ Appointment and Cancellation Policy

If you are unable to keep a schedule appointment, please notify our office as early as possible. Timely cancellation of your appointment allows the office to manage our schedule efficiently, ultimately improving our availability to yourself and other patients. Failure to cancel within 24 hours of the appointment may result in a $25 missed appointment charge for clinic visits and a $100 charge for surgical appointments. Each and every surgical case requires a great deal of preparation from our staff to address all insurance and pre-operative issues. Thus, if you need to cancel or reschedule an appointment, you MUST call at least 24 hours before your scheduled time.

✓ Financial Policy and Collection Fee Disclaimer

Copayments are due on the day of service.

Surgical services: Deductible and coinsurances are due on the day services are rendered. Our office will contact your insurance to determine the estimated amount. We recognize that your insurance policy may indicate your deductible is not due until after your insurance has paid. However, our financial policies require these amounts up front. Our billing office will contact you prior to your procedure to discuss any amount over your normal copay amount.

Our office considers all balances due within 30 days after the initial patient statement has been issued.

I, the undersigned, agree that if this account is not paid when due, to reimburse the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

Bowling Green Dermatology and Skin Cancer Specialists, PLLC/Glasgow Dermatology reserves the right to dismiss patients with delinquent accounts.

✓ Release of Medical Information

I, the undersigned, consent to the use and disclosure of my protected health information (PHI) by Bowling Green Dermatology and Skin Cancer Specialists, PLLC's to carry out treatment, payment and operations (TPO), such as forwarding information to my primary care or referring physician.

I also give consent for Bowling Green Dermatology & Skin Cancers Specialists, PLLC to request records on my behalf from or to other providers as they deem necessary for my treatment at their facility. This signed form will also serve as consent to release my records to other providers as Bowling Green Dermatology and Skin Cancer Specialists, PLLC's deems necessary or at my request.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in regards to my prior consent. If I do not sign this consent or later revoke it, Bowling Green Dermatology & Skin Cancer Specialists, PLLC may decline to provide treatment for me.

✓ Adult Students

We file claims on behalf of our patients, however if you are over the age of 18, you are responsible for your bill. We will need your current address for billing purposes for our files. If your parent wishes to pay your bill, please provide your bill to them.

✓ Minors

A parent or legal guardian must accompany all children under the age of 18. In the case of divorced parents, the parent bringing the child in for service is responsible for the bill.

✓ Insurance Referrals

It is the responsibility of the patient or guardian to obtain the necessary insurance referral (if required) in order for your insurance company to pay for your services. Please check with your insurance plan to see if a referral or pre-authorization is necessary. If you arrive to your appointment without the required referral, you can either reschedule the appointment or assume total financial responsibility for the services that day.

✓ HIPAA Notice of Privacy Practices

A copy of our Notice of Privacy Practices for Bowling Green Dermatology & Skin Cancer Specialists, PLLC is available at the front desk if you desire to have a copy.

COWAN DERMATOLOGY

HEALTH HISTORY

Patient Name: _____ Date of Birth:_____

Please list any medications that you are currently taking: ☐ I am not currently taking any medications.

_____ _____ _____ _____

_____ _____ _____ _____

Do any of the following conditions apply to you? (please check all that apply) ☐ None apply

- ☐ Acne
- ☐ Artificial heart valve
- ☐ Artificial joints/metal implant
- ☐ Atopic dermatitis
- ☐ Atypical moles
- ☐ Autoimmune disease (e.g. Lupus, RA)
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Cold sores/herpes
- ☐ Currently breastfeeding
- ☐ Currently pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Heartburn/reflux
- ☐ HIV/AIDS
- ☐ Keloid formation/scarring
- ☐ Kidney disease
- ☐ Liver disease/hepatitis
- ☐ Lung disease
- ☐ Psoriasis
- ☐ Seasonal allergies/asthma
- ☐ Skin cancer (basal cell/squamous cell)
- ☐ Skin cancer (melanoma)
- ☐ Skin pre-cancers (actinic keratosis)
- ☐ Thyroid abnormalities
- ☐ Ulcers
- ☐ Other conditions: _____

Are you allergic to any medications, anesthetics or food?

☐ Yes Please list allergies: _____
☐ No _____
_____
_____

Please list surgeries/hospitalizations with approximate dates (if known):

Date: _____ Type: _____
Date: _____ Type: _____
Date: _____ Type: _____
Date: _____ Type: _____

Please list only the IMMEDIATE FAMILY (mother, father, sister, brother or child) that have had any of the following with CURRENT STATUS (alive/deceased):

☐ Melanoma:
Relationship: _____ Status: _____
Relationship: _____ Status: _____

☐ Squamous cell carcinoma
Relationship: _____ Status: _____
Relationship: _____ Status: _____

☐ Basal cell carcinoma
Relationship: _____ Status: _____
Relationship: _____ Status: _____

☐ Psoriasis
Relationship: _____ Status: _____

☐ Eczema
Relationship: _____ Status: _____

☐ Other cancer: Type: _____
Relationship: _____ Status: _____
Relationship: _____ Status: _____

Do you smoke? Please note the following smoking and alcohol information is collected as a requirement by health care regulators.

☐ Yes ☐ No

If yes, how often?
☐ Everyday ☐ Some days

How soon upon waking do you first smoke?
☐ 5 min ☐ 6-30 min ☐ 31-60 min ☐ Past 60 min

How many cigarettes do you smoke daily?
☐ < 5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ >31

Are you interested in quitting?
☐ Ready to quit ☐ Thinking of quitting ☐ Not ready to quit

Have you consumed an alcoholic beverage within the past year?
☐ Yes ☐ No

How often did you have 6+ drinks on one occasion in the past year?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

How many drinks are typical for you daily?
☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

How often did you have a drink of alcohol in the past year?
☐ Monthly or less ☐ 2-4 times monthly ☐ 2-3 times weekly ☐ 4+ times weekly

Do you use smokeless tobacco? ☐ Yes ☐ No
Do you currently use a tanning bed? ☐ Yes ☐ No
Do you regularly use sunscreen? ☐ Yes ☐ No
Have you ever had a blistering sunburn? ☐ Yes ☐ No
Do you use recreational drugs? ☐ Yes ☐ No

Please list your occupation: _____

Have you recently experienced any of the following conditions?

- ☐ Fever
- ☐ Chest pain
- ☐ Joint aches
- ☐ Difficulty urinating
- ☐ Headache
- ☐ Nausea/vomiting
- ☐ Leg swelling
- ☐ Depression
- ☐ Easy bruising
- ☐ Muscle aches
- ☐ Vision changes
- ☐ Weight change

Please record your recent height and weight below: (approximate)

Height: _____ft _____ in Weight: _____ lbs