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Patient Registration Form

Today's Date _____

Patient's Name: _____ **Date of Birth:** _____ Age: ____
First Middle Last Month Day Year

□ Married □ Single □ Divorced □ Widowed Sex: □ M □ F **Occupation:** _____

Address: _____
Street number Apt/Unit #

_____
City State Zip

Social Security Number: _____ Drivers License # _____

Employer: _____
Name/Address

Home Phone: _____ may we leave confidential messages on your answer machine □ yes □ no

Cell phone _____ may we send you text messages such as appointment reminders □ yes □ no

Work Phone: _____ may we leave messages at your place of work □ yes □ no

Email address _____ Would you like to receive Email from our office □ yes □ no

Do we have your permission to:
Discuss your medical condition with another member of your household? □ YES □ NO
Discuss your billing and/or financial information with anyone else? □ YES □ NO

If yes, whom: _____ Relationship _____

In case of emergency, notify: Name _____ Contact number _____

Referred by: _____

Responsible Party: _____ Contact phone _____

INSURANCE INFORMATION:
Please present insurance cards and photo ID to the receptionist so copies may be made.

Primary insurance: □ Blue Cross □ Blue Shield □ Motion picture □ Medicare □ PPO □ other □ none
Subscribers name: _____ DOB: _____ Relationship to insured: □ self □ spouse □ child
Secondary Insurance : □ Blue Cross □ Blue Shield □ Motion picture □ Medicare □ PPO □ other □ none
Subscribers name: _____ DOB: _____ Relationship to insured: □ self □ spouse □ child

OFFICE POLICIES:

- All co-payments, deductibles and non-covered services are due at the time of service.
- All cosmetic procedures are to be paid at the time of service. These are not billed to the insurance.
- It is the responsibility of the patient to understand their individual policy. Please be aware that co-payment amounts may not be applicable for any type of surgical service performed.
- Appointments must be cancelled 24 hours in advance. All non-cancelled appointments may be subject to charge.
- Medical debt will not impact a patient's credit score, and collection agencies cannot report it to credit reporting agencies.

_____ _____
Patient Signature **Date**

MEDICATIONS:
List all medications you are currently taking including prescriptions, over the counter products, vitamins and herbs.

_____
_____
_____
_____

Pharmacy_____

Pharmacy Address:_____

ALLERGIES: ☐ NONE
Drug allergies: (list type of reaction)

_____

☐Anesthetics ☐Aspirin
☐Codeine ☐Erythromycin
☐Penicillin ☐Sulfa
☐Tetracycline ☐Other

NON-DRUG ALLERGIES:
☐Food ☐Tape
☐Anesthetic ☐Other

_____

SURGERIES: ☐ NONE
List previous surgeries and dates

_____
_____
_____
_____
_____
_____

Primary Doctor:_____

Doctor's Phone#_____

PERSONAL MEDICAL HISTORY: Do you now have, or ever had any of the following conditions

Disease	Yes	No
Skin Cancer	☐	☐
Arthritis, muscle, joints	☐	☐
Asthma, eczema, allergies	☐	☐
Eyes	☐	☐
Diabetes, thyroid disorder	☐	☐
Blood, bleeding problems	☐	☐
Lupus, autoimmune disorder	☐	☐
Psychological disorders	☐	☐
Headaches, seizures	☐	☐
Stomach, bowel, kidney	☐	☐

Disease	Yes	No
Heart disease, pacemaker	☐	☐
High blood pressure	☐	☐
Other skin diseases	☐	☐
Malignant melanoma	☐	☐
Skin cancer	☐	☐
Tuberculosis	☐	☐
HIV, Aids, Hepatitis	☐	☐
Ear, nose, throat, mouth	☐	☐
Lungs	☐	☐

FAMILY MEDICAL HISTORY: Do you or anyone in your family now have, or ever had any of the following conditions

Disease	Yes	No
Skin Cancer	☐	☐
Abnormal moles	☐	☐
Asthma, eczema, allergies	☐	☐

Disease	Yes	No
Malignant melanoma	☐	☐
Skin disease	☐	☐

SOCIAL HISTORY: Check all that apply

Do you smoke? ☐No ☐Yes-Frequency: _____
Do you use IV drugs? ☐No ☐Yes-Frequency: _____
Do you drink alcohol?☐No ☐Yes-Frequency _____
Have you had or been exposed to HIV (AIDS)? ☐ Yes ☐No
Do you use sunscreen? ☐No ☐Yes-Frequency_____
How would you rate the amount of time spent outdoors: high / moderate / low
What are your hobbies: _____
What is your occupation? _____

THANK YOU FOR COMPLETING THIS FORM.
THIS WILL ALLOW US TO EVALUATE YOUR SKIN CONDITION MORE COMPLETELY

HEALTH HISTORY QUESTIONS:

Have you been advised to take antibiotics before any surgery or dental work?.....□YES □NO

Do you take blood thinners, anticoagulants or aspirin?..... □YES □NO

Do you develop keloids (scars) after surgery? .....□ YES □ NO

(Women) Are you pregnant or breastfeeding.....□ YES □ NO

Have you ever been examined by a Dermatologist before?.....□YES □NO

Have you ever been treated for the same condition for which you are being seen?.....□YES □NO

Is there any other info that you feel is important for the doctor in evaluating your medical condition..... □YES □NO

If yes, Explain

_____

_____

_____

Why are you seeing the doctor today?

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors and/or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Completed by: □Patient □ Medical Assistant _____
(Initial) (Physician initials)

I have reviewed this patient health history form: _____ Date _____

THANK YOU FOR COMPLETING THIS FORM.
THIS WILL ALLOW US TO EVALUATE YOUR SKIN CONDITION MORE COMPLETELY

Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually protected health information (PHI) used or disclosed by us in any form; electronically, paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and correct how your health information is used.

Our practice is committed to securing the privacy of your health information. Accordingly, we have posted a brief explanation of our Privacy Practices in our office and have made available a copy of the entire policy at your request.

We would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Signature: _____ Print name: _____

Date: _____

If not signed by the patient, please state your relationship and patient name

Relationship: _____ Patient _____

Assignment and Release

I authorize treatment of the individual named as "patient" and understand that Daphne Panagotacos, M.D., Inc. will file a claim with my insurance company for services rendered and I authorize payment of medical insurance benefits to be made to my treating physician.

I also authorize Daphne Panagotacos, M.D., Inc. to release or obtain any medical information related to the treatment of "patient".

Signature of responsible Party_____

Treatment consent for unaccompanied minor

Many times, parents find themselves unable to accompany their teen or young adult children to appointments. This statement has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Daphne Panagotacos MD, Inc. permission to treat my child when they arrive at the office unaccompanied.

Parent/Legal guardian Signature _____Date _____

Medicare Patients, please fill out

YES	NO	
☐	☐	Have you recently joined a Medicare HMO? If yes, identify: _____
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through that insurance at that job? If yes, name of employer: _____
☐	☐	Is this illness covered by the VA (Veteran's Administration)?
☐	☐	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness due to an automobile accident?
☐	☐	Is this illness due to an injury at work?
☐	☐	Do you have dependent coverage?
☐	☐	Are you receiving Medicaid/Medi-Cal?
☐	☐	Do you have Secondary insurance coverage? If yes, name of carrier: _____

PAYMENT OF SERVICES:
Our doctors do accept assignment from Medicare which means they accept what Medicare allows. However, Medicare pays 80% of their allowable charges. Our office will bill your supplemental policy (when applicable) after receipt of Medicare's payment. Any balance remaining after this due to deductible, carve out plans, non-covered services, etc., will be the patient's responsibility to pay.

Patient signature_____ **Date**_____

MEDICARE LIFETIME ASSIGNMENT
This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I request that payment of authorized Medicare benefits be made to me or on my behalf to the physician(s) listed for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits for related services. I permit a copy of this authorization to be used in place of the original.

Insured's signature _____ **Date**_____
(As appears on Medicare card)

MEDIGAP ASSIGNMENT (*If you have a supplemental policy, we are required to keep a separate signature on file)*
I authorize any MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize release of information needed to determine these benefits for related services.

This authorization is in effect until I choose to revoke it.

Insured's signature _____ **Date**_____
(As appears on insurance card)

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We would greatly appreciate you taking a moment to help us identify our referral sources....

How did you hear about Daphne Panagotacos, M.D., Inc.?

- ☐ A member of my family recommended the doctor.
- ☐ A friend recommended the doctor:
- ☐ Another doctor recommended the group:

If you would like us to keep your physician informed, please give us the doctor's name _____

- ☐ The doctor's name was listed in my insurance directory of preferred providers.
- ☐ I noticed your ad in the Yellow Pages
- ☐ I saw your name on the internet.
- ☐ I have been seen as a patient previously in this office

Other: _____

Please check any services that you would be interested in receiving further information on:

- ☐ Restylane Injection (Filler material for facial smile & expression lines)
- ☐ Perlane
- ☐ Juvederm
- ☐ Botox (For frown and squint lines)
- ☐ Glycolic acid products for face and body
- ☐ Skin care Products
- ☐ Cosmetic facials
- ☐ Dysport injections (For frown and squint lines)
- ☐ Radiesse
- ☐ Sclerotherapy treatment for spider leg veins
- ☐ IPL – Genesis (photofacial)
- ☐ Glycolic peel for acne, discoloration, and fine lines
- ☐ Microdermabrasion
- ☐ Laser Hair Removal

What other services would you like to see offered:

_____

Would you like us to mail you further information on the above services? ☐ yes ☐ no
Would you like to be included in our email notifications? ☐ yes ☐ no

Name: _____

Email address _____

Thank you for taking the time to complete this survey.

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