

BLUEGRASS DERMATOLOGY AND SKIN SURGERY CENTER, PSC

Registration Patient Information (Please Print)

Date: _____ Chart Number: _____

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ____/____/____ SSN: ____-____-____ Sex: FEMALE MALE Race: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Home Address: (Primary) _____

City: _____ State _____ Zip Code _____

Occupation: _____ Employer: _____

Email Address: (List only if you wish to be contacted via email) _____

Person to notify in case of an emergency: _____ Phone: () _____

How did you hear about our practice? Referring Physician Friend Phone Book Other _____

Primary Physician: _____ Phone Number: () _____

Referring Physician: _____ Phone Number: () _____

Bluegrass Dermatology utilizes an automatic electronic system for prescriptions. Please fill in the following info:
Primary Pharmacy Name: _____ Phone Number: () _____
Primary Pharmacy Address: _____ City/State: _____ Zip Code: _____

NAME & DOB OF INSURED: (If Different from the Patient) Name: _____ DOB: ____/____/____
Insurance companies require this information for claim processing. SSN: ____-____-____

PARENT and/or GUARDIAN : (If Patient is under the age of 18):
Last Name: _____ First Name: _____ Middle Name: _____
Home Address: (Primary) _____
City: _____ State: _____ Zip Code: _____
Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
DOB: ____/____/____ SSN: ____-____-____ Sex: FEMALE MALE Employer: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company, including, but not limited to co-pays, deductibles and co-insurance payments.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan with which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of CASH, CHECK, VISA, MASTERCARD, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS. We also participate with Care Credit Financing. All balances due that do not get paid within the first 30 days are subject to finances which will accrue interest monthly.

PATIENT or Responsible Party Signature: _____ Date ____/____/____
(PLEASE SIGN HERE)

Patient Information: Medical History (Please Print)

Date: _____

Chart Number: _____

Last Name: _____ First Name: _____ M.I.: _____ DOB ____/____/____

MEDICATION INFORMATION: I am NOT Currently Taking Any Medication(s) (Check only if applicable)

List all medications you are now taking (include over-the-counter medicines and herbal preparations):

(Please fill in the medication information as completely as possible.)

Medication(s)	Dosage	How Often Taking Medication	Prescribed By

MEDICAL ALLERGY INFORMATION: (Please fill in completely as possible, only your medical allergy information.)

LATEX ALLERGY (Please check) No Yes

ALLERGIES TO OTHER SUBSTANCES No Yes

(List Medical Allergies to other substances if you answer yes)

ANESTHETIC or LIDOCAINE ALLERGY No Yes

ALLERGIES TO MEDICATIONS No Yes *(If you answer Yes, please list medication allergies below)*

Medication Allergy	Reaction

PERSONAL MEDICAL HISTORY: (Check all that apply) I have no personal medical problems (Check only if applicable)

- | | | | | |
|---------------------------------------|--|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives | <input type="checkbox"/> Lupus | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Mitral Valve | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Prolapse | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Keloids / Scars | <input type="checkbox"/> Phlebitis or blood clots | <input type="checkbox"/> Vein treatments |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Kidney Disease | | <input type="checkbox"/> Other _____ |

List All Previous Surgeries: _____

FAMILY HISTORY: (Check all that apply)

- | | | | | |
|---------------------------------------|-----------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Other _____ |

Do You Use: Alcohol Cigarettes Coffee Caffeine

Females Only: (Check all that apply) Are you: Pregnant Trying to Conceive Taking Birth Control Pills

PATIENT or Responsible Party Signature: _____ Date ____/____/____
 (PLEASE SIGN HERE)