BLUEGRASS DERMATOLOGY
Patient Registration Form

Date: ______________________________ **Chart Number:** ____________________________________

PATIENT DEMOGRAPHIC INFORMATION

Name: ____ Social Security Number: _______________________ Birth Date: ________________

Address: ____________________________________ Apt. / Suite: ______________ City/State/Zip: ____

E-mail Address: ____**(REQUIRED FOR PATIENT PORTAL ACCESS)**

Home Phone: (_____)_____________________ Cell Phone: (_____)______________________

Preferred Number: [ ]Home [ ]Cell Can we leave a detailed Message: [ ]Yes [ ] No Method for reminders? [ ] Phone call [ ] Text [ ] E-mail [ ] All Three

Race: [ ] Caucasian [ ] African American [ ] Hispanic / Latino [ ] Asian [ ] American Indian [ ] Other ____

Ethnicity: [ ] Hispanic [ ] Non-Hispanic Gender Identity: [ ] Male [ ] Female [ ] Trans Male [ ] Trans Female [ ] Androgynous [ ] Other Pronoun: ______

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Primary Language: ____

Employer: ____ Address: ____

City/State/Zip: ____ Work Phone: (______)________________________________

Emergency Contact Name: ____ Relationship: _________________ Phone: (_____)____________________

RESPONSIBLE PARTY BILLING INFORMATION Relationship to Patient: [ ] Self [ ] Parent [ ] Guardian [ ] POA [ ] Other ______________

Name: ____________________________________ Birth date: _______________________ Address: ____

City/State/Zip: ____ Social Security Number: _________________________

INSURANCE INFORMATION

Please double check your insurance card to see if a referral is required by your PCP (your PCP's name will be printed on the front copy of your card or you may see "referral required") in order to be seen by a specialist. If so, the referral authorization must be received by our practice PRIOR to your appointment. Insurance plans will NOT accept a referral request by our office.

Primary: ____ I.D. #: ____

Group #: __________________________ Effective Date: ______________________ Subscriber Birth Date: ________________

Subscriber Name: _____________________________________ Gender: ____________________ Relationship to Patient: _____________________

Secondary: ____ I.D. #: ____

Group #: __________________________ Effective Date: ______________________ Subscriber Birth Date: ________________

Subscriber Name: _____________________________________ Gender: ____________________ Relationship to Patient: _____________________

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, DISCOVER, AMERICAN EXPRESS, 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.

PHARMACY AND PRIMARY CARE PROVIDER (Per Medicare and most insurances, you are required to list a primary care provider [PCP])

Pharmacy Name: ____ Address: ____

City/State/Zip: ____ Phone: (____)__________________________

Physician: _________________________________ City/State/Zip: ____ Phone: (____)_________________

PATIENT SIGNATURE (or Parent/Guardian or POA): ____________________ Date: ____________

BLUEGRASS DERMATOLOGY
Patient Medical History Form

Patient Name: ____________ **Birth Date:** ____________ **Chart Number:** ____________

Were you referred here by another physician for a specific issue? ___Yes ___No

If Yes: Physician's name:____________ Phone Number: ____________

MEDICAL HISTORY (circle all that apply) [ ] I do not have any medical history problems and/or conditions

Anxiety
Asthma
Bleeding Problems
Blood Clots
Cancer ____________
Depression
Diabetes
Heart Disease
Hepatitis
High Blood Pressure
HIV / AIDS
Inflammatory Bowel
Disease
Kidney Disease
Liver Disease
Migraines/Headaches
Pacemaker
Seizures
Stroke
Thyroid Disorders
Tuberculosis
Tumors ____________
Other ____________
____

SURGICAL HISTORY (circle all that apply) [ ] I do not have any past surgical history

Skin Cancers ____________
____
____
Skin Biopsy ____________
Brain or Spine Surgery ____________
Breast or Gynecological ____________
Heart / Lung Surgery ____________
Joint Surgery ____________
Liver / Kidney Surgery ____________
Prostate or Testicular ____________
Stomach/Intestine/Colon ____________
Other Cancer Surgery ____________

SKIN MEDICAL HISTORY (circle all that apply) [ ] I do not have any skin medical history problems and/or conditions

Basal Cell Carcinoma
Melanoma
Skin Cancer (unknown type)
Squamous Cell Carcinoma
Acne
Actinic Keratoses
Allergies
Atypical or abnormal moles
Blistering Sunburns
Eczema
Flaky or Itchy Scalp
Poison Ivy
Psoriasis
Skin Infections
Tanning Bed Use

MEDICATION INFORMATION [ ] I am not currently taking any medications

(List all medication you are currently taking and include all over-the-counter medications, herbals, vitamins, and minerals)
It is important you fill in ALL of the fields for each medication

Medication(s) Name (What is the name of the medication?)	**Strength Unit** (Strength of medication)	**Route** (How you take it? ie oral, injection, under tongue, etc)	**Dose** (How many taken?)	**Dose Form** (ie tablet, capsule,liquid, gel, etc)	**Frequency** (How often is medication taken?)	**Indication** (What medical condition does it treat?

PATIENT SIGNATURE (or Parent/Guardian or POA): ____ **Date:** _____________________

BLUEGRASS DERMATOLOGY
Patient Medication/Allergy History Form

Patient Name: ______________________________ **Birth Date:** ________________ **Chart Number:** _______________

ALLERGY INFORMATION [ ] I do not have any allergies to any medications

Medication	Allergic Reaction

Do you have an allergy to Latex Products? ☐ No ☐ Yes
Do you have an allergy to Lidocaine? ☐ No ☐ Yes
Do you have an allergy to Adhesives? ☐ No ☐ Yes
Do you have an allergy to Topical Antibiotic Ointments? ☐ No ☐ Yes

SOCIAL HISTORY (Please answer **ALL** of the following questions)

[ ] Never smoker and/or tobacco user [ ] Former smoker and/or tobacco user [ ] Current smoker and/or tobacco user

[ ] I do not drink alcohol [ ] I drink alcohol

[ ] I have had flu vaccine current / past flu season [ ] I have not had flu vaccine [ ] I do not take flu vaccine [ ] I am allergic to the flu vaccine

[ ] I have had pneumonia vaccine [ ] I have not had pneumonia vaccine [ ] I do not take pneumonia vaccine [ ] I am allergic to the pneumonia vaccine

[ ] I have had 1st Pfizer / Moderna Covid vaccine [ ] I have had 2nd Pfizer/Moderna Covid vaccine [ ] I have had Johnson & Johnson Covid vaccine
[ ] I have NOT had any Covid vaccine(s) [ ] I do not take any Covid vaccine(s) [ ] I am allergic to Covid vaccine(s)

Surrogate Decision Maker (i.e. Living Will, POA, or family member / friend who can help you in medical emergencies)
[ ] I have a surrogate decision maker [ ] I do not have a surrogate decision maker [ ] I have a living will [ ] I have a POA

If you have a surrogate decision maker, who is it? ____________________________ Phone: (______)______________________

FAMILY HISTORY (circle all that apply) [ ] I do not have a family history of any medical conditions

Please do not include yourself and/or spouse and only list family member(s) who had the medical condition

Melanoma (family member ________________________)
Other Skin Cancers [unknown type]
(family member ________________________)
Cancer (family member ____________________________)
Diabetes (family member ____________________________)
Eczema or Psoriasis (family member _________________)
Other Pertinent Family History____

PATIENT SIGNATURE (or Parent/Guardian or POA): ____ **Date:** _____________________

BLUEGRASS DERMATOLOGY
Patient Review of Systems Questionnaire Form

Patient Name: ______________________________ **Birth Date:** ________________ **Chart Number:** _______________

Are you currently experiencing any of the following? (Please mark Yes or No for the following):

SYMPTOMS			SYMPTOMS		
Abdominal Pain	☐ No	☐ Yes	Rash	☐ No	☐ Yes
Blurry Vision	☐ No	☐ Yes	Problems with Bleeding	☐ No	☐ Yes
Chapped Lips	☐ No	☐ Yes	Problems with Scarring/Healing	☐ No	☐ Yes
Depression	☐ No	☐ Yes	Changing Mole	☐ No	☐ Yes
Dry Skin	☐ No	☐ Yes	Thyroid Problems	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Sore Throat	☐ No	☐ Yes
Joint Pain	☐ No	☐ Yes	Muscle Weakness	☐ No	☐ Yes
Swollen Lymph Nodes	☐ No	☐ Yes	Night Sweats	☐ No	☐ Yes
Fever and Chills	☐ No	☐ Yes	Seizures	☐ No	☐ Yes
Cough	☐ No	☐ Yes	Heartburn	☐ No	☐ Yes
Nausea or Vomiting	☐ No	☐ Yes	Wheezing	☐ No	☐ Yes
Unintentional Weight Loss	☐ No	☐ Yes			

Please mark Yes or No for the following:

- **Do you take a blood thinning medication?** Common blood thinning medications are: Aspirin, Brilinta (Tricagrelor), Coumadin (Warfarin), Plavix, Pradaxa, Xarelto, Imbruvica (Ibrutinib) ☐ No ☐ Yes
- **Do you have an artificial heart valve?** ☐ No ☐ Yes
- **Do you require antibiotics prior to a surgical procedure?** ☐ No ☐ Yes
- **Do you have a defibrillator and/or pacemaker?** ☐ No ☐ Yes
- **Have you had an artificial joint replacement within the past two (2) years?** ☐ No ☐ Yes
  If yes, when and what body locations? ______________________________
- **Have you been diagnosed as having human immunodeficiency virus (HIV)?** ☐ No ☐ Yes
- **Have you been diagnosed as having Hepatitis B or C?** ☐ No ☐ Yes

FEMALE PATIENTS PLEASE ANSWER THE FOLLOWING QUESTIONS:

- Are you trying to become pregnant? ☐ N/A ☐ No ☐ Yes ☐ Maybe
- Are you currently pregnant? ☐ N/A ☐ No ☐ Yes ☐ Maybe
- Are you currently nursing? ☐ N/A ☐ No ☐ Yes
- If you are of child-bearing potential, are you using contraception? ☐ N/A ☐ No ☐ Yes
  If yes, what contraception are you currently using? ____

PATIENT SIGNATURE (or Parent/Guardian or POA): ____ **Date:** ____________________

Bluegrass Dermatology Office Policies & HIPAA
(Health Insurance Portability and Accountability Act) Consent Form

The following is a review of our office policies and Insurance Portability and Accountability Act (HIPAA). Please review and sign below. Some policies may not pertain to your treatment today, but may for future treatments / procedures.

- **Payment responsibility:** The patient is ultimately responsible for all insurance deductibles, co-pays and coinsurance on the day of service (subject to plan limitation, and exclusions). We are not a Medicaid-provider and do not bill to Medicaid.
- **Payment options (For procedures not covered by insurance or balance dues):** Cash, check, Visa, Discover, American Express, Mastercard, Care Credit Visa, debit cards, money orders, and cashiers checks. Payment plans can be arranged with CareCredit Visa by GE Moneybank. All balances due that do not get paid within the first 30 days are subject the account being transferred to an outside collection agency. You can apply for CareCredit in our office today.
- **Insurance policies that require a referral from PCP**: Some insurance plans require a referral from the patient's primary care provider (or PCP). This referral needs to be initiated by the patient's PCP, by contacting the patient's insurance company. This is the only way the patient will receive benefits when seeing a specialist. **It is the patient's responsibility to make sure this has been done prior to each appointment date. Otherwise, the patient is responsible for ALL charges.**
- **Network Providers:** It is your responsibility to know if your provider is considered "In-network" by your insurance. Some insurance companies change their policy administrator and this can be difficult to identify from your insurance card. We encourage you to confirm your In-network status with our office each time you receive a new copy of your insurance card. **We are not a Medicaid provider and Medicaid does not offer out of network benefits; we do not bill to Medicaid and therefore patients will not receive reimbursement from their Medicaid plan.**
- **Prescription refill policy:** Our physicians prescribe their patients sufficient refills to last until their next follow-up appointment; therefore, we are unable to refill prescriptions by telephone. If you would like refills of any medications prescribed by one of our physicians, please ask the physician you are seeing today during your exam.
- **Laboratory facilities:** All surgical pathology and other lab specimens are submitted to outside laboratories for processing and analysis. The patient will receive a separate bill from the laboratory that processes and tests specimens. It is the patient's responsibility to let us know if your insurance company requires that we send your labs to a specific pathologist in order for you to receive full benefits.
- **Additional Fee:** There is a $25 fee assessed if you fail to cancel or reschedule an appointment at least 24 hours prior or you no-show the appointment.

As required by the **Health Insurance Portability and Accountability Act (HIPAA) of 1996**, this practice may use your health information for the purposes of treatment, payment, or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Information Practices by describing the restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

- 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. We accept payment in the form of cash, check, Discover, American Express, Visa, Mastercard, debit cards, money orders, and cashiers checks. We also participate with Care Credit Financing.
- **Acknowledgement of Receipt of Privacy Practices:** I acknowledge the practice has a copy (as well as displayed in their lobby) of the Notice of Privacy Practices which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information, and that I can obtain a copy per request.
- **Consent to Treat:** I hereby authorize examination and treatment by Bluegrass Dermatology. I authorize release of any medical information necessary to process claims to insurance carriers (and/or the Social Security Administration/CMS or intermediaries) and I assign payments for medical services to the physician(s). I understand that it is my responsibility to remit payments for charges not covered by my insurance company. I understand that it is my responsibility to see

that all claims, pre-certifications and authorizations are completed by my insurance company, since I am responsible for all professional services rendered to myself and/or dependent. I permit a copy of this authorization to be used in place of the original. All information gathered will remain confidential by our HIPAA policy.

CONSENT: I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

- I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.
- I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to this practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.
- Is there anyone (i.e. spouse, parent, guardian or family member) you authorize us to share any medical information with, if you are not available? [ ] YES [ ] NO
  - If yes, please provide their name & contact information below:

Name: ___________________________________ Relationship: _____________________

Home Phone: _______________________________ Cell Phone: ____________________

RESTRICTION REQUEST SECTION ***If you do NOT want the physicians or staff at Bluegrass Dermatology to leave test result; appointment; or billing/account information on your personal voicemail, please make note in the Restriction detail below.

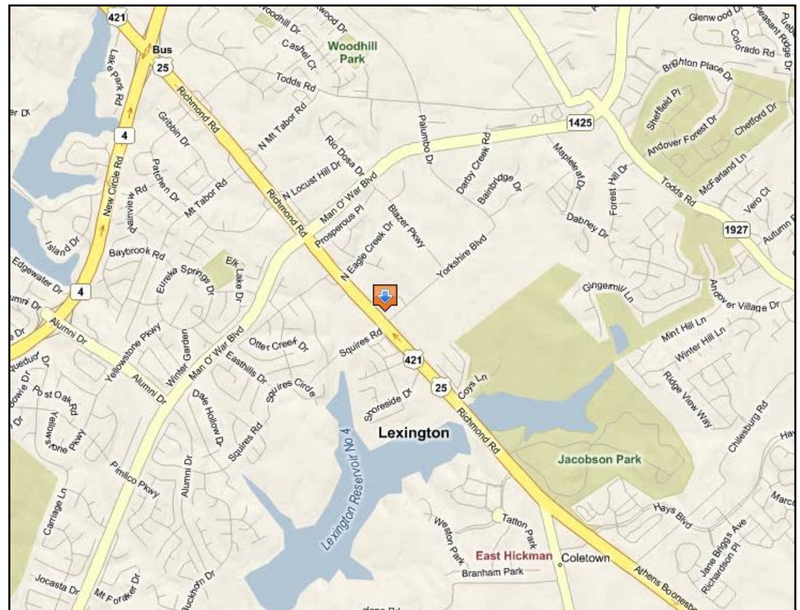
I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

____

* If you are over 18 years of age and under your parent's insurance policy, please check the box: [ ]

Signature of Responsible Party: ____ Date: ___________________

Driving Directions to the Office



Hours of Operation:

Monday – Thursday: 8 am – 6 pm
Friday: 8 am – 5 pm
Closed: Weekends and Major Holidays

Coming From Interstate 75 South:

1. At exit 104, take ramp right for KY-418 toward Lexington / Athens.
2. Turn left onto SR-418 / Athens Boonesboro Rd
3. Road name changes to US-25 North / US-421 North / Richmond Rd.
4. Turn right onto Yorkshire Blvd, our parking lot is the first drive to your left.

Coming From Interstate 75 North:

1. Take the Man O'War Blvd exit #108 – KY-1425W.
2. Stay straight on Man O'War Blvd and turn left onto Palumbo Drive.
3. Stay straight on Palumbo Dr, there will be a sharp turn to the right and the road name changes to Yorkshire Blvd.
4. Stay on Yorkshire Blvd to the end. Our parking lot is the last drive on your right.

Coming from New Circle Road:

1. Take the US-25S./US-421S. exit #15 towards Richmond / Interstate 75.
2. Stay on Richmond Rd heading towards Interstate 75.
3. After crossing Man O'War Blvd, turn left at the 2nd traffic light, onto Yorkshire Blvd.
4. Our parking lot is the first drive to your left.

Coming from the Bert T. Combs Mountain Parkway:

1. Take the Mountain parkway to Interstate 64 W.
2. Merge onto I-75 S. via exit 81 on the left towards Richmond / Knoxville.
3. Take the Man O'War Blvd exit#108 – KY-1425W.
4. Stay straight on Man O'War Blvd and turn left onto Palumbo Drive.
5. Stay straight on Palumbo Dr, there will be a sharp turn to the right and the road name changes to Yorkshire Blvd.
6. Stay on Yorkshire Blvd to the end. Our parking lot is the last drive on your right.