

BEND DERMATOLOGY CLINIC, LLC

REGISTRATION FORM

PATIENT INFORMATION

Last Name	First Name	Initial	Employer	Home Phone
Mailing Address			Soc Sec #	Occupation
City			State	Zip
Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Emergency Phone

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Company	Insurance Company
Address or /COPY OF CARD	Address or /COPY OF CARD
Employer	Employer
Group # ID #	Group # ID #
Policyholder	Policyholder
Relationship to Patient	Date of Birth
Relationship to Patient	Date of Birth

RESPONSIBLE PARTY-BILLING INFORMATION

Last Name	First Name	Initial	Soc Sec #	Home Phone
Mailing Address			Employer	Employer Phone
City	State	Zip	Birthdate	Age
			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Emergency/Cell Phone

MISCELLANEOUS INFORMATION

Nearest Relative _____ Phone/Cell _____

Address _____ Referred By _____

Street City State Zip

Primary Care Physician _____

Do we have your permission to:

- Leave a message on your answering machine at home? Yes No
- Leave a message at your place of employment? Yes No
- Discuss your medical condition with a household member? Yes No

If yes, with whom: _____ Relationship: _____

ASSIGNMENT AND RELEASE

I, request that payment of authorized Medicare benefits be made on my behalf to Bend Dermatology Clinic for services furnished me by any of the clinic providers. I authorize any holder of medical information about me to release the Centers for Medicare & Medicaid services and its agents any information needed to determine benefits payable for these or related services. I understand my signature authorizes the payment and the release of medical information necessary to pay the claim. If "other health insurance" is indicated on this registration form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown. In Medicare assigned cases, Bend Dermatology Clinic agrees to accept the charge determination of the Medicare carrier as the full charge, and I understand that I will billed only for the deductible, coinsurance and noncovered services based on the determination of the Medicare carrier.

X _____

Signature of Patient or Responsible Party

Date

I have read and understand Bend Dermatology's Financial Policy

Initial _____

Bend Dermatology Clinic, LLC
Personal Medical History

NAME _____ DATE OF BIRTH _____

MEDICATION ALLERGIES: _____

NON-MEDICATION ALLERGIES: Latex _____ Others (IVP dye, food dye, etc) _____

DO YOU REGULARLY TAKE ASPIRIN? Yes No

CURRENT MEDICATIONS: _____

MEDICAL HISTORY:(check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Malignant melanoma |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding, excessive | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarring/keloids |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes simplex (cold sores) | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Colon/intestinal disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives | <input type="checkbox"/> Ulcers |

Other condition(s) describe _____

Women Only: Currently taking birth control pills Currently pregnant

SURGICAL HISTORY (past 2 years) _____

SOCIAL HISTORY: Do you smoke/chew tobacco? Yes No Drink alcohol? Yes No

FAMILY HISTORY: Is there a history in your family of the following diseases?

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Allergies/hayfever | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Malignant Melanoma | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | |

Other Condition(s) describe _____

Signature of Patient

Date