Rabin-GreenbergDermatology
Houston 713.797.6171
www.RGderm.com

Dermatology Associates of Sugar Land
Sugar Land 281.313.0006
www.SLderm.com

Kingwood Dermatology
Kingwood281.358.7600
www.KWderm.com

Date:_____

PATIENT REGISTRATION

PATIENTINFORMATION

LASTNAME_____

FIRSTNAME_____ MIDDLE_____

SOCIAL SECURITY#_____

DATEOFBIRTH_____ SEX MALE FEMALE

MARITALSTATUS MARRIED SINGLE DIVORCED WIDOWED

DRIVERS LICENSE #_____ STATE_____

*BILLING ADDRESS _____

CITY_____ST_____ZIP_____

HOME ADDRESS_____

CITY_____ST_____ZIP_____

HOMEPHONE (_____)_____

CELL PHONE (_____)_____

WORK PHONE (_____)_____

EMAIL:_____

WORK. STATUS EMPLOYED STUDENT RETIRED

EMPLOYER_____

ADDRESS_____

CITY_____ST_____ZIP_____

REFERRING PHYSICIAN _____

HOW DID YOU HEAR OF US?_____

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARDTO THE RECEPTIONIST)

INSURANCECOMPANY_____PHONE #_____

POLICY HOLDER'SNAME_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER'SSS#_____ POLICY HOLDER'S DOB_____

POLICY HOLDER'S ID/POLICY_____ GROUP #_____

HOME ADDRESS_____CITY_____ST_____ZIP_____TEL #_____

POLICY HOLDER'S EMPLOYER:_____EMPLOYER PHONE_____

SECONDARYINSURANCEINFORMATION

INSURANCECOMPANY_____PHONE #_____

POLICY HOLDER'SNAME_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER'SSS#_____ POLICY HOLDER'S DOB_____

POLICY HOLDER'S ID/POLICY_____ GROUP #_____

HOME ADDRESS_____CITY_____ST_____ZIP_____TEL #_____

POLICY HOLDER'S EMPLOYER:_____EMPLOYER PHONE_____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR/ADULT CHILD)

THE PARENT / GUARDIAN WHO BRINGS IN THE MINOR/ADULT CHILD WILL BE RESPONSIBLE FOR ALL COPAYMENTS AND DEDUCTIBLES. WE DO NOT FORWARD BILLS TO OTHER PARTIES REGARDLESS OF COURT RULINGS OR DIVORCE DECREES.

LAST NAME_____ ADDRESS_____

FIRST NAME_____MIDDLE_____ CITY_____ST_____ZIP_____

SOCIAL SECURITY #_____DAYTIMEPHONE_____

DRIVERS LICENSE #_____EMPLOYER_____

DATE OF BIRTH_____ SEX MALE FEMALEADDRESS_____

RELATIONSHIP_____CITY ST_____ZIP _____

BY SIGNING BELOW, I UNDERSTAND I WILL BE RESPONISIBLE FOR ANY CHARGESINCURRED FOR THE MINOR/ADULT CHILD.

PARENT/ GUARDIAN_____DATE _____

Patient Health History

In order to treat you safely and effectively, please answer the following questions. This is for our records only, and responses are confidential.

Name:_____ Age:_____ Height:_____ Weight:_____

What is the reason for your visit? _____

_____

How long has this been present? _____

Allergies to medications? No Yes (please specify) _____

Medications (please include non-prescription meds and birth-control pills; write "no" if none):

_____

_____

_____

Do you use aspirin or blood thinners daily? Yes No

If you are female: Are you pregnant? Yes No Breastfeeding?_____ Yes_____ No

Past Medical History/Family History

	Yourself	Blood relative
Lupus, rheumatoid arthritis, other joint disease	□	□
Cancer	□	□
Diabetes	□	□
Eczema	□	□
Hay fever, allergies hives	□	□
Hepatitis – Type?_____	□	□
Dysplastic nevi (abnormal moles)	□	□
Malignant melanoma	□	□
Psoriasis	□	□
Skin cancer (basal cell or squamous cell)	□	□
Thyroid disease	□	□
HIV/AIDS	□	□

Review of Systems

	Yourself	Blood relative
Transplantation	□	□
Heart Disease	□	□
Heart murmurs or MVP	□	□
Artificial valve/Pacemaker	□	□
High blood pressure	□	□
Bleeding disorder	□	□
Blood transfusions	□	□
Joint Aches	□	□
Artificial Joint	□	
Psychiatric Disorder	□	
Bowel Disease (Crohn's/colitis)	□	
Fever	□	□

List other medical problems_____

_____

Prior surgeries_____

_____

Social history: Marital Status:_____ Occupation:_____

Do you smoke? No Yes (packs/day: _____) Do you drink alcohol? No Yes (quantity: _____)

Patient Signature: X _____ **Date:** _____

Reviewed by:_____ Date: _____

Financial Policy

We are committed to providing you with quality medical care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, financial policy, or your responsibility.

REGARDING INSURANCE – Please be prepared to present your current insurance card and identification to front office upon request.

Contracted Managed Health Care Plans (PPO, POS, EPO, MC). Each time you make an appointment it is your responsibility to make sure this office is currently under contract with your plan and you have obtained the necessary referrals prior to your appointment. We will file your insurance if we are providers for your plan. If you are not sure what your benefits are please contact your insurance company before any treatment is provided. You may need to schedule another appointment to have treatment done if you wish to obtain this information first. **Payments of co-payment, co-insurance, deductible, or fees for non-covered services are required at time of service. Any amounts billed to the patient will be due upon receipt of first billing statement.**

REFERRALS. Some insurance plans may require a referral from a referring doctor (PCP). If your insurance requires such a referral, you must have that information before or at the time of your scheduled appointment. **You may try to obtain the referral when you are at this office however we ask if you are not able to obtain the referral before your appointment time that you pay for your visit in full and file for a reimbursement from your insurance company or reschedule your appointment for a later date in order to acquire your referral.**

Medicare. This office accepts assignment of TRADITIONAL MEDICARE benefits only. We will file a claim to Medicare for you. Payment of deductible, co-insurance, or fees for non-covered services, when applicable, will be billed to the patient. We are not providers of MEDICARE ADVANTAGE OR REPLACEMENT PLANS (Humana, Aetna, Texas Plus, United Healthcare. etc.). If you are not sure if you have TRADITIONAL MEDICARE please ask our front office to verify before you see the doctor. We do not file secondary or tertiary insurance coverage. If your secondary coverage participates with Medigap then Medicare will electronically forward your claim to your secondary insurance. If not then you would be responsible for balance Medicare does not pay and can file for reimbursement from any insurance coverage beyond Medicare.

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered/covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" other than to supply factual information as necessary. You are responsible for the timely payment of your account.
After 60 days, it is the patient's responsibility to pay the balance of the account even if there is an insurance claim pending. We will no longer be responsible for collecting your insurance claim or for negotiating a settlement of a disputed claim.

By signing below I acknowledge that I am 18 years of age or older. **I have read and understand the above terms and conditions and verify so by giving my signature.**

Patient/Responsible Party **X** _____ Date _____

Assignment: I hereby authorize payment directly to this office. I agree to the release of any and all medical information, including test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within 30 days of the effective date.

Patient/Responsible Party **X** _____ Date _____

Information and Consent for Treatment

Insurance plans and their coverage vary greatly. We try hard to work with our patients to make sure they receive the maximum legal benefits from their provider. In order to do this however, we must have your current provider card and all required information regarding your insurance at the time of your appointment. **Without this accurate information you will be responsible for the charges incurred at time of visit.**

REFERRALS

Some insurance plans may require a referral from a referring doctor. If you insurance requires such a referral, you must have that information before or at the time of your scheduled appointment. You may try to obtain the referral when you are at this office. **However, we ask if you are not able to obtain the referral before your appointment time that you pay for your visit in full and file for a reimbursement from you insurance company or reschedule your appointment for a later date in order to acquire your referral**.

TREATMENTANDSURGICALPROCEDURES

Some insurance plans also have a deductible for "SURGICAL PROCEDURES AND TREATMENTS DONE IN THE OFFICE." When any type of growth* is removed from the skin by excision, biopsy, liquid nitrogen to FREEZE growth, including extractions and injections, most insurance plans consider this as an "IN OFFICE SURGICAL PROCEDURE OR TREATMENT." If your surgical deductible has not been met, you will be responsible for these charges.

PATHOLOGY

***ANYTIME A GROWTH IS REMOVED FROM THE SKIN, THE TISSUE WILL BE AUTOMATICALLY SENT FOR PATHOLOGY.**

This is considered a separate charge in addition to the biopsy fee and may be billed by our Dermatopathologist or sent to an outside lab for processing. If you should have any question regarding this process, please inquire before the procedure or treatment is done.

If you are not sure of, or concerned about your plan benefits, please advise our staff BEFORE ANY PROCEDURE OR TREATMENT IS PERFORMED.

I have read and understand the above information. By signing below I acknowledge that I am 18 years of age or older and I voluntarily give my permission and authorize the doctors/assistants as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from this practice or until I withdraw my consent in writing. I also understand and agree to be responsible for any fees the insurance company does not pay.

Patient/Responsible Party_____ Date_____

Cancellation Policy

To provide better service to our patients, we ask that you read the following policy and **acknowledge by signing the bottom of the page.**

24 hour notice for any cancellations or rescheduling of appointments is required; this includes all appointments (general surgical, cosmetic and laser). **If you cannot cancel 24 hours prior to your appointment you may be subject to a cancellation fee.**

Cosmetic Appointments

The following appointments require a deposit.

Fillers$300.00
Sclero$100.00

All deposits are non-refundable if the appointment is not canceled 24 Hours prior to your appointment time. If your appointment is on a Monday, the appointment must be canceled by Friday. If you have any questions please feel free to ask. Thank you.

Patient Signature:_____

Date:_____

Cosmetic Interest Questionnaire

Patient Name:_____ Date:_____

Please check any cosmetic concerns or procedures of interest:

( ) Cool Sculpting (fat reduction)
( ) Botox Cosmetic
( ) Dermal Fillers *(Juvéderm, Radiesse, Belotero, Restylane Silk or Sculptra)*
( ) Laser Hair Reduction
( ) Photo Rejuvenation *(to reduce appearance of sun spots, age spots and rosacea)*
( ) Chemical Peels *(acne, melasma, sun spots, uneven tone and texture, fine lines)*
( ) Clear & Brilliant (*facial scarring, texture, melasma and pore reduction*)
( ) Fraxel Resurfacing Laser *(facial scarring and texture)*
( ) Rosacea Treatment
( ) Leg Vein Treatment *(sclero therapy)*
( ) Skin Care & Sunscreens
( ) Skin Tightening
( ) Micro-Needling

Have you ever had any cosmetic treatments before? List treatments and how satisfied you were:

_____
_____
_____

Main concern with skin:

_____
_____
_____

Would you like to have a cosmetic consult in person or by phone with the Licensed Medical

Aesthetician? ( ) YES ( ) NO

Phone Number: _____

Would you like to receive emails when we are having cosmetic

specials? ( ) YES ( ) NO

Email Address: _____

Consent to Treat for Minor

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

You may appoint anyone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their medical appointment.

Minor's Full Name_

Last Name First Name Middle Name

Date of Birth_____

For occasions when you may not be with your child, please list those individuals who may give us consent to treat your child.

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____Initial here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for_____days only.

_____Initial here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for indefinitely, until revoked by written consent.

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent or legal guardian must be in attendance.

It is the policy of this office that the adult presenting the child for treatment, or the child if they are seen without an adult present, is responsible for payment of the patient portion at the time of service. I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____

Parent or Legal Guardian Printed Name Parent or Legal Guardian Signature

_____ _____

Date Relationship to Patient

Medicare Patient Questionnaire

Patient Name:_______________________________ □ Jr □ Sr

DOB:_______________________ Today's Date:______________

Answer the following questions below by placing a check in the appropriate column:

YES	NO	
□	□	Have you recently joined a Medicare Advantage Plan? If yes, identify:___________________________
□	□	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
□	□	Are you covered by a commercial PPO/HMO which makes Medicare Secondary.
□	□	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?
□	□	Are you receiving Medicaid?
□	□	Is this due to a Disability?

^^

Office Use Only

12 Working Aged
13 End Stage Renal Disease
14 Auto/Med/No-Fault Liability (ESRD)
15 Workers Compensation
16 Fedral Agency (Public Health)
41 Federal Black Lung
42 Veterans Affairs
43 Disability
47 Other Liability

Notification of Non Medicaid Providers

Patient:_____ Date of Birth:_____/_____/_____

Rabin Greenberg Dermatology

Kingwood Dermatology

Dermatology Associates of Sugar and

Primary Insurance: _____

YOUR SIGNATURE BELOW SIGNIFIES THAT YOU CLEARLY UNDERSTAND THAT:

The physician's of Rabin-Greenberg Dermatology, Kingwood Dermatology and Dermatology Associates of Sugar Land are **NOT MEDICAID PROVIDERS**. Today's visit will be your responsibility if not paid by your primary insurance (as noted above).

This means we will file to your primary insurance plan only and **WILL NOT** file any claims to Medicaid. In the event your primary insurance plan does not make payment to us, or it is applied to deductible, co insurance, or is not covered, you would have to pay the balance due in full at time of billing.

Do not sign this form unless you absolutely understand the consequences of your visit and the charges you will have to pay out of pocket.

I UNDERSTAND ALL OF THE ABOVE AND STILL WANT TO RECEIVE SERVICES FROM THE NON-PARTICIPATINGPHYSICIANTODAY.

Signature of Patient:_____ Date: _____

Signature of Guardian:_____ Date: _____