DATE ____________________

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME ______________________________

FIRST NAME ________________ MIDDLE __________

SOCIAL SECURITY # ________ – ________ – __________

DATE OF BIRTH _____ / _____ / ________ SEX ☐ M ☐ F

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

DRIVER'S LICENSE # ____________ STATE ________

HOME ADDRESS ______________________________

CITY ______________ ST ______ ZIP ________

HOME PHONE (______) ________ – __________

CELL PHONE (______) ________ – __________

WORK PHONE (______) ________ – __________

WORK STATUS ☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ OTHER

EMPLOYER ______________________________

ADDRESS ______________________________

CITY ______________ ST ______ ZIP ________

REFERRING PHYSICIAN ____________________

HOW DID YOU HEAR OF US? ____________________

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

☐ COMMERCIAL ☐ MEDICARE ☐ SELF-PAY ☐ OTHER ______________________________

INSURANCE COMPANY ______________________________ PHONE (_____) ______ – ________

POLICY HOLDER'S NAME ______________________ RELATIONSHIP TO PATIENT______________

POLICY HOLDER'S D.O.B. _____ / _____ / _______ ID/POLICY # ______________ GROUP # ______________

HOME ADDRESS ______________ CITY __________ ST ___ ZIP ______ TEL # (_____) ______ –________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ______________________________ PHONE (_____) ______ – ________

POLICY HOLDER'S NAME ______________________ RELATIONSHIP TO PATIENT______________

POLICY HOLDER'S D.O.B. _____ / _____ / _______ ID/POLICY # ______________ GROUP # ______________

HOME ADDRESS ______________ CITY __________ ST ___ ZIP ______ TEL # (_____) ______ –________

EMERGENCY CONTACT

NAME (LAST, FIRST) ______________________ TEL # (_____) ______ – ________ ☐ HOME

RELATIONSHIP TO PATIENT __________________ # (_____) ______ - ________ ☐ CELL / ☐ WORK

PARENT/LEGAL GUARDIAN IF PATIENT IS MINOR

THE PARENT / GUARDIAN WHO BRINGS IN THE MINOR 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 ______________________________

FIRST NAME ______________ MIDDLE ________

SOCIAL SECURITY # ______________________

DRIVERS LICENSE # ______________________

DATE OF BIRTH _____/_____/_______ SEX ☐ M ☐ F

RELATIONSHIP ______________________________

ADDRESS ______________________________

CITY ______________ ST ______ ZIP ________

DAYTIME PHONE (______) ________ – __________

EMPLOYER ______________________________

ADDRESS ______________________________

CITY ______________ ST ______ ZIP ________

BY SIGNING BELOW, I UNDERSTAND I WILL BE RESPONISIBLE FOR ANY CHARGES INCURRED FOR THE MINOR CHILD.

PARENT / GUARDIAN ______________________________ DATE ____________________

NEW 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	☐	☐
Hayfever, 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

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: ________________

Cosmetic Interest Questionnaire

Name:____ Date:____________________

Doctor you will be seeing today:____

I am interested in learning more about the following:

( ) BOTOX® Cosmetic
( ) Restylane ® or Juvederm ®
( ) Radiesse ® or Sculptra ®
( ) Microdermabrasion
( ) Chemical Peels
( ) IPL Laser to reduce brown and red spots of the skin
( ) Laser Hair Removal
( ) Medical Facial
( ) Rosacea Treatment
( ) Fraxel Resurfacing Laser
( ) Leg Vein Treatment
( ) Skin Care & Sunscreens

Please answer the following questions by circling the appropriate response:

1) When looking at my face in the mirror, I believe I look:
   a) younger than my true age
   b) my true age
   c) older than my true age

2) I am concerned about the appearance of my facial wrinkles:
   a) not concerned
   b) somewhat concerned
   c) very concerned

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

Would you like our office to contact you with more information on cosmetic treatments?
( ) YES ( ) NO

Contact Phone Number:____

Email Address:____

Rabin-Greenberg Dermatology
Houston 713.797.6171
www.RGderm.com

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

Kingwood Dermatology
Kingwood 281.358.7600
www.KWderm.com

Information and Consent for Treatment

As we are sure our patients know insurance plans and their coverages 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 required information regarding your insurance at the time of your appointment. **Without this accurate information you will be responsible for the charges incurred at the time of your visit.**

Some insurance plans may require a referring doctor. If your insurance requires such a referral, you must have that information before or at the time of your scheduled appointment. If you try to obtain the referral when you are at this office and delay your examination, our schedule and all of our subsequent patients will be unfairly delayed. Please reschedule your appointment.

Some insurance plans also have a deductible for "**SURGICAL PROCEDURE**." When any type of growth is removed from the skin by excision, biopsy, liquid nitrogen to freeze the growth, including milia extraction, most insurance plans consider this as a "**SURGICAL PROCEDURE**." **If your surgical deductible has not yet been met, you will be responsible for these charges**.

Any time a growth is removed from the skin, the tissue will be automatically sent for pathology unless otherwise indicated by the doctor. This is considered a separate charge in addition to the biopsy fee. If you should have any question regarding this process, please inquire before the procedure is done.

If you are not sure of, or concerned about your plan benefits, please advise our staff BEFORE any procedure is performed.

Do we have 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 any member of your household?	Yes	No

If yes, who: ____________________Relationship_____________________________________

I have read and understand the above information. By signing below, I authorize the doctor to perform the procedure indicated and agree to be responsible for any fees my insurance company does not pay.

Patient/Responsible Party **X** __________________________________ Date ____________________

^^^

I agree that this consent for treatment will remain in effect for the duration of my association with this practice.

Patient/Responsible Party **X** __________________________________ 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.

To assist us in establishing your account (1) provide current insurance information on our registration form, and (2) authorize release of information necessary for insurance filing and pre-certification (by providing your signature below). Failure to do so will affect your financial responsibility for charges incurred. Payments can be made by cash, check, or credit card (Visa, MasterCard, American Express).

REGARDING INSURANCE

Contracted Managed Health Care Plans (HMO, PPO, POS, EPO). 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. Verification of your plan is required. Often this verification obligates us to share the reasons for your visit with your managed care plan. Please expect to show your current card to our staff upon request.
Payments of co-payment are required at time of service.
Co-insurance, deductible, or fees for non-covered services, when applicable, will be billed to the patient and due upon receipt of statement.

Medicare. This office accepts assignment of Medicare benefits. 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.

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.

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. Any changes to this authorization must be received in writing within 30 days of the effective date.

Patient/Responsible Party **X** ______________________________________ Date ________________________

^^

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, for an indefinite period 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 ________________________

RABIN-GREENBERG DERMATOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ____HAVE VIEWED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

ON BEHALF OF MINOR CHILD, PARENT, OR SPOUSE, ____, AS THEIR PARENT, LEGAL GUARDIAN, OR EXECUTIER. (PATIENTS NAME)

I HAVE LISTED BELOW FOUR PEOPLE (IF APPLICABLE) WHO MIGHT BE INVOLVED IN HIS/HER MEDICAL UPDATES AND/OR TRANSPORTATION.

NAME PHONE NUMBER RELATIONSHIP

1. ____

2. ____

3. ____

4. ____

PLEASE PRINT NAME

SIGNATURE OF PATIENT OR GUARDIAN

DATE: ____

* A COPY OF OUR HIPPA POLICY IS AVAILABLE UPON REQUEST.

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

_____ INDIVIDUAL REFUSED TO SIGN

_____ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

_____ EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

_____ OTHER (PLEASE SPECIFY) ____

____