DSCS Patient Registration **DATE**________________

Patient Registration Information

PATIENT ______________________________ Age ________ Date of Birth __________

Mailing Address ________________________ SSN ________________ M or F

______________________________ Home Phone __________________

Physical Address ____

Cell Phone ________________________ email: ________________________

Employer____________________________ Occupation ________________________

Work Address __________________________ Work Phone __________________________

SPOUSE ____________________________ Date of Birth ________________________

Employer ____________________________ Social Security No. ____________________

Work Address __________________________ Work Phone __________________________

GUARANTOR ____________________________ **Relationship to Patient** ______________________

EMERGENCY CONTACT:____________________________ **Phone #** ____________________

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RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT, AND AGREEMENT TO PAY FOR SERVICES

I hereby authorize **DSCS** to release any information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance/Medicare claim for the period of **LIFETIME**. I claim any insurance benefits due me for services rendered by **DSCS** and authorize and direct my carrier to issue payment check(s) directly to **DSCS**. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

____ ________________________

Patient Signature **DATE**

Patient History Form

Name: ______________________ Date of birth: ___________ Today's date: _________

Reason for today's visit: ____

Past Medical History

Have you ever had skin cancer: Y N If yes, what type: Basal Squamous Melanoma

Has anyone in your family had skin cancer: Y N
If yes, what type: Basal Squamous Melanoma

Have you or anyone in your family had abnormal moles: Y N

Have you or anyone in your family had keloids: Y N

Do you use tobacco: Y N Do you use alcohol: Y N

Are you pregnant, breastfeeding, or trying to become pregnant: Y N

Heart problems:	Y	N	Lung problems:	Y	N
Chest pain:	Y	N	Diabetes:	Y	N
Blood clots:	Y	N	Murmur:	Y	N
Liver problems:	Y	N	Hepatitis:	Y	N
Pacemaker:	Y	N	Seizures:	Y	N
Thyroid problems:	Y	N	Kidney problems:	Y	N
High Cholesterol:	Y	N	Artificial joints:	Y	N
Cancer (if yes, list type):____________			HIV/AIDS:	Y	N

Allergies: Y N If yes, please list:____________________________________

Medications: Please list or attach a separate list. You may need to call your pharmacy to get the names of medications.

1.____________________ 2.____________________ 3.__________________
4____________________ 5.____________________ 6.__________________
7.____________________ 8.____________________ 9.__________________
10.___________________ 11.___________________ 12.__________________

Occupation:__________________ **Hobbies:**_________________________

Pharmacy Name and Phone Number:____________________________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Patient/Legal Guardian Signature________________________________

Medical Information Release Form

(HIPAA Release Form)

Name: ________________________________ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse________________________________

[ ] Child(ren)______________________________

[ ] Other_________________________________

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_______________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (*day*)______________ between (*time*)________

Signed: ________________________________ Date: ____/____/____

Witness:________________________________ Date: ____/____/____