DSCS Patient Registration

Date: ____________________

Patient _________________________________ Age ___________ DOB _________________

Mailing Address: ___________________________ SSN: _____________________ M or F

____ Home Phone ______________________

Physical Address ____

Cell Phone ________________________ Email _____________________________________

Employer ____

Employer Address ____

Employer Phone ______________________________ Occupation ______________________

<u>SPOUSE</u> _________________________________ DOB ________________________________

Phone __________________________________ SSN _________________________________

Employer ____

Employer Address ____

GUARANTOR ______________________________ Relationship to Patient ______________

Emergency Contact _________________________ Phone ______________________________

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 a period of **LIFETIME.** I claim any insurance benefits due me for services rendered by **DSCS** and authorize direct my carrier to issue payment 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

Date ________________

Name ____ DOB _______________________

Reason for today's visit ____

<u>Past Medical History</u>

Do you have a living will: Y N

Have you ever had skin cancer: Y N Type: Basal Squamous Melanoma

Has anyone in your family had skin cancer: Y N 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 (raised Scars): 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 type):	**Y**	**N**	**HIV/AIDS:**	**Y**	**N**

____

ALLERGIES: ____

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

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Pharmacy Name ________________________ 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 ____

DSCS Medical Information Release Form

(HIPPA Release Form)

Patient Name_____________________________________ DOB________________________

Release of Information

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

[ ] Spouse____

[ ] Children____

[ ] Other ____

[ ] Information is NOT to be released to anyone.

This RELEASE OF INFORMATION will remain in effect until terminated by me in writing.

<u>MESSAGES</u>

Please Call: [ ] HOME [ ] CELL [ ] WORK

If unable to reach me:

[ ] You may leave a detailed message.

[ ] Please leave a message asking me to return your call.

[ ] Other _______________________________________

The best time to reach me is (day)_______________________ between (time)_____________

Signature ____ Date _____________________