PATIENT REGISTRATION FORM

****

PATIENT INFORMATION

Name (First)_____(M.I.)_____(Last)_____

Street asdfasdf_____Apt # _____ City_____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Birthdate _____ SSN_____ Sex: M___ F___ Race _____ Age _____

Employer_____ Work Phone _____

Marital Status: M___ S___ D___ W___ Separated___ Spouse's Name _____

E-Mail Address: _____

****

RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)

Name _____ SSN _____

Address _____ City _____ State_____Zip_____

Home Phone _____ Cell Phone_____ E-Mail: _____

Employer_____ Work Phone _____

****

INSURANCE INFORMATION

Primary Insurance Company _____ Insured's Date of Birth_____

Name of Insured _____ ID# _____ Group # _____

Secondary Insurance Company _____ Insured's Date of Birth_____

Name of Insured _____ ID# _____ Group # _____

****

Who referred you to this office? _____

What type problem are you having? (be specific):

_____

Have you been treated for this problem by another doctor? Yes_____ No_____

If yes, who and when? _____

Do you feel the problem is work related? Yes_____ No_____

****

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE ACCESS TO DR. FREEMAN'S PUBLIC NOTICE OF PRIVACY PRACTICES. I ALSO ACKNOWLEDGE THAT MY PROTECTED HEALTH INFORMATION (PHI) WILL BE RELEASED FOR THE SOLE PURPOSE OF: 1) TREATMENT, 2) PAYMENT AND HEALTHCARE OPERATIONS (SUCH AS BILLING AND COLLECTION), AND 3) OUTSIDE LABORATORY SERVICES (ALL SPECIMENS OBTAINED VIA BIOPSY OR OTHER SURGICAL METHOD WILL BE SENT TO AN OUTSIDE PATHOLOGIST FOR TISSUE EXAMINATION. I UNDERSTAND THAT I WILL BE BILLED SEPARATELY BY THE PATHOLOGIST). BY REFUSING TO SIGN, I COULD FORFEIT MY RIGHT TO ANY HEALTHCARE SERVICES. UNLESS OTHERWISE NOTED, PAYMENT IS DUE AT THE TIME OF SERVICE.

Signed _____ Date _____

Patient (Parent/Guardian)

(Please complete side 2 <u>except</u> for shaded areas).

PROBLEM LIST (*PHYSICIAN USE ONLY*)

PROBLEM	DIAGNOSIS	DATE	PROBLEM	DIAGNOSIS	DATE

Have you ever been treated by another dermatologist? No___ Yes___ If yes, who?_____
City/State_____ Dates of care_____
Females, are you pregnant? No___ Yes___ Trying ___ Due Date:_____ Nursing? No___ Yes___
Do you smoke? No___ Yes___ How much? _____ packs a day Oral tobacco? No___ Yes___
Do you drink alcoholic beverages? No___ Yes___ What type and how often?_____
Do you use any type of recreational drugs? No___ Yes___ What type and how often?_____

Allergies to Medications? (circle) No Yes (If yes, list medication and type of reaction below; ex: sulfa, A,B)

1._____ 2._____ 3._____ 4._____
Type of Reaction: A) Rash/hives, **B)** swelling, **C)** nausea, **D)** diarrhea, **E)** GI upset, **F)** chest tightening, **G)** racing heart or **H)** headache
Allergies to local anesthetic? No Yes Which one?_____
Type of Reaction:(circle) Rash/hives swelling nausea diarrhea GI upset chest tightening racing heart headache

Oral Prescription Medications			**Non-Prescription**
1.	4.	7.	1.
2.	5.	8.	2.
3.	6.	9.	3.

Topical prescription medications:

1._____ 2._____ 3._____ 4._____

Patient's past history:

Previous skin problems N Y what?_____
Skin Cancer N Y type?_____
Hay Fever/Asthma N Y Tuberculosis N Y
Psoriasis N Y HIV/AIDS N Y
Diabetes N Y Hepatitis N Y
Internal cancer N Y type?_____
_____
Other_____
Hospitalizations or surgeries (last 10 years)
Reasons_____
_____
_____
When_____

Family History:

diabetes N Y
psoriasis N Y
skin cancer N Y
hay fever/asthma N Y
internal cancer N Y type?_____
_____
other skin diseases_____
_____
other problems_____
_____
_____
_____

William E. Freeman, M.D.
DERMATOLOGY

Patient Consent and Questionnaire
(Read document in its entirety before signing)

1. **Please list the family members (including spouse, children) or other persons, *if any*, whom we may inform about your general medical condition and your diagnosis (please list phone #'s if different than home):**

   _____

   _____

   _____

2. **Can messages (ie. appointment reminders) be left on your home answering machine? Yes ___ No ___ No Answering Machine Available ___**

3. **Can we contact you at your workplace or leave a message on your voicemail? Yes ___ No ___ N/A ___**

4. **It is Dr. Freeman's office policy to send *all* specimens (no exceptions) of the skin removed by biopsy or other surgical method to an outside pathology laboratory. You will be billed a separate charge by the laboratory. Your signature below indicates that you understand and comply with Dr. Freeman's policy regarding outside laboratory services.**

5. **It is Dr. Freeman's office policy that minors must be accompanied by a parent and/or legal guardian on their *initial* office visit. Minors must be accompanied when having a surgical procedure. After the initial office visit, minors of driving age can come unaccompanied (non-surgical procedures) as long as parent/guardian consents that said minor is understanding of treatment, prescriptions, follow up care instructions.**

6. **It is Dr. Freeman's office policy to confirm office appointments by telephone or mail.**

7. **It is Dr. Freeman's office policy to submit necessary personal health information (PHI) to insurance companies for purposes of billing and receiving payment.**

8. **It is Dr. Freeman's office policy to mail monthly statements to your residence.**

9. **It is Dr. Freeman's office policy to mail monthly dunning letters when necessary to collect for past-due accounts. Accounts are considered past due 30 days from the initial date of service.**

(Please complete side 2 on back of this page.)

136 South Houston Lake Road • Warner Robins, Georgia 31088
Telephone (478) 953-1020 • Fax (478) 953-5406

11. **It is Dr. Freeman's office policy to collect all medical fees incurred. If incurred fees remain unpaid, your account will likely be referred to an outside entity for further collection process. The nature of your medical history and medical record will remain confidential and will be retained by the practice; however, personal identifying information such as name, address, phone number, responsible party, social security number will be released.**

12. **You have the right to request, in writing, how Dr. Freeman uses or discloses your personal health information(PHI) to carry out treatment, payment and health care operations (TPO); *however,* the practice is not required to agree to your requested restrictions but if it does, it is bound by those restrictions.**

13. **You have the right to review the six page Notice of Privacy Practices (located at Reception) at any time. You have the right to obtain a personal copy of the Notice of Privacy Practices.**

By signing this form, I am consenting to Dr. Freeman's use and disclosure of my PHI to carry out TPO. I may revoke this consent at any time by submitting a request in writing to the Office Manager/Privacy Office. If I do not sign this consent, Dr. Freeman may decline to provide treatment to me. (The sole purpose of this consent is to protect your right to privacy according to the Health Insurance Portability and Accountability Act which passed in August, 1996 and became effective April 14, 2003).

_____ _____

Signature of Patient or Legal Guardian **Print Name of Patient or Legal Guardian**

_____ _____

Relationship to Patient **Patient's Name if different than above**

_____**Date**