

GERMAIN DERMATOLOGY
NEW PATIENT REGISTRATION

Last Name, First Name _____ Middle Initial _____

Nickname _____

SSN#: _____ Date of Birth: _____ Age: _____

Sex: M / F Marital Status: S M D W Military: Y / N If yes, are you Retired? _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Guardian /Parent Name (if patient is under 18): _____

Guardian/Parent SSN#: _____ Guardian/Parent Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Emergency Contact: _____ Phone Number: _____

Do you have a Primary Care Physician? Yes No
If so, who? _____ Phone Number: _____

Were you referred by a Physician to our practice? Yes No
If so, who? _____ Phone Number: _____

Primary Insurance: _____ Policy Holder's Name: _____

Policy Holder's SSN# (REQUIRED): _____ Policy Holder's DOB: _____

Secondary Insurance: _____ Policy Holder's Name: _____

Policy Holder's SSN# (REQUIRED): _____ Policy Holder's DOB: _____

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST.
THANK YOU.

I hereby authorize the physician to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original.

Signature of Patient or Parent/Guardian: _____ Date: _____

Germain Dermatology Medical History

Chart #: _____

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

Are you pregnant? y n Are you nursing? y n Are you trying to become pregnant? y n

Are you allergic to any medications? y n If yes, list below:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Are you allergic to any of the following?

Local Anesthetic (lidocaine) y n Latex y n Adhesive Tape y n

List all current medications (ie: prescriptions, birth control, over the counter, supplements and vitamins):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Do you take aspirin or any other "blood thinners" on a regular basis? y n

Do you have now or have you ever had any of the following:

	Y	N		Y	N		Y	N
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>						
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
DEFIBRILATOR	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	History of Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	History of Depression	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Atypical Moles	<input type="checkbox"/>	<input type="checkbox"/>
Gastroesophageal	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Precancerous Skin	<input type="checkbox"/>	<input type="checkbox"/>
Reflux Disease (GERD)			Syndrome (IBS)			Lesions		

Cancer y n Type: _____

Family History of skin cancer y n Type: _____

Have you ever skin cancer? Basal Cell y n Squamous Cell y n Melanoma y n

Do you drink alcohol? y n Number of drinks per week: _____

Do you smoke? y n Number of packs per week: _____

List all previous surgeries:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

What is your reason for be seen today? _____

Patient/Guardian Signature: _____ Date: _____

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

**Germain Dermatology
Questionnaire**

Patient Name: _____ **Date:** _____

Health issues and procedures/products of interest to you (please circle all that apply).

Botox	Acne	Age Spots	Mineral Makeup
Dermal Fillers	Rosacea	Fine Lines/Wrinkles	Skincare
Facial Peels	Facial Veins	Dry Skin	Laser Hair Removal
Eyelash Enhancement			

Other Concerns: _____

How did you learn about this practice? _____

Were you referred to the practice by a patient? If so, by whom? _____

Would you like to receive emails regarding practice specials and upcoming events? _____

Email Address: _____

Patient Signature _____

THANK YOU!

Self-Paying Patients

Patients seen at nearly every physician's office fall into 1 of 2 financial categories:

1. An insurance company provides payment through a healthcare policy purchased by an employer for an employee, or purchased by an individual. (Insured)
2. A patient pays the physician directly for healthcare services. (Self-Pay)

Germain Dermatology is dedicated to you and your well-being. We promise to do our best to provide you with the highest possible care available. We know that medical care is expensive. For whatever reason you are presently without insurance coverage, we want you to know that both your physical and financial interests are considered as we treat your illness, but we are primarily dedicated to treating that illness as effectively as we can.

In many cases, your care and our consideration of your needs continue long after you have left the office. As a private practice, we are not subsidized by any government or private programs. We offer our service to you at a competitive price that is comparable to any other Dermatology practice in the area.

For us to remain efficient and viable, we ask that you consider our needs as well. As a Self-Pay patient, we must ask that you pay for treatment at the end of each visit. Unfortunately for both you and the physician, it is impossible to determine what the cost of that care will be prior to it being given. We will do our best to inform you of what to expect along the way, but please understand that we do not have control over the cost of many of the elements involved in that care (lab tests, medications, injectables, medical supplies). We are working hard to try and keep our costs down. Please know that when we see you face-to-face, your best care is our only objective. In return, we ask that you treat our staff with the same kindness and respect they offer you, and that you pay for the services you have received before you leave the clinic.

Sincerely,

Marguerite A. Germain, MD

Patient's/Guardian's Signature _____

Date _____

Dr. Marguerite Germain and her Staff Want You to Know How We Will Protect Your Private Health Information

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act (“HIPAA”). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- **Give patients more control over the health information**
- **Set boundaries for the use and release of health records**
- **Establish safeguards that physicians, health plans and other healthcare provider must have in place to protect the privacy of health information**
- **Hold violators accountable, with civil and criminal penalties**
- **Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.**

The HIPAA rules require that our practice provide all our patients that we see after August 2005 with attached Notice of Privacy Practices. The notice describes how the medical information we receive from you may be use or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Office Manager.

Thank you for your cooperation.

I acknowledge that I have received a copy of the practice’s Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name: _____

Signature of Patient or Personal Representative: _____ **Date:** _____

If Personal Representative, state relationship to patient:

**CONSENT TO DISCLOSE INFORMATION TO FAMILY MEMBER
AND/OR PERSONAL REPRESENTATIVE**

- Do you authorize Germain Dermatology to discuss your medical treatment with anyone other than yourself (including but not limited to prescriptions, lab results, etc.)? Please check one of the following:

YES

NO

If yes, please indicate representative below :

*****if name is not listed, we *CANNOT* disclose any of your information to anyone other than yourself*****

1. Family Member/Personal Representative: _____

Relationship to Patient: _____

Phone Number: _____

2. Family Member/Personal Representative: _____

Relationship to Patient: _____

Phone Number: _____

- What is the best number to reach you during working hours (8am-5pm)?

Home _____ Work _____ Cell _____

Conditions for Disclosure: (please check the item(s) that apply)

- The practice may disclose my personal health information to the individuals above only in my presence.
- The practice may disclose my medical information to the individuals above in discussions in my presence and when I am not physically present, including disclosures by telephone, fax, email or regular mail.
- Other Conditions of Disclosure: _____

I, _____, understand I am designating the above mentioned person as my representative. I acknowledge that Germain Dermatology has my authorization to disclose my private health information to my designated representative for all purposes while lawfully observing all HIPPA privacy rules and regulations. I also understand that designating someone as my representative is an optional choice and I may choose not to do so at this time by leaving the above form blank. This consent may be revoked by me at any time by written notice to the practice and will expire in one year.

Signature of Patient

Date

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name: _____ **Date:** _____

I consent for medical photographs to be made of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Germain Dermatology, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Germain Dermatology at 843-881-4440.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

- 1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes at Germain Dermatology and to be used in my medical record.

Patient Signature _____ Date _____

- 2) I agree for my image to be shown for teaching purposes **AND** to be used for my medical record but **NOT FOR** medical publication.

Patient Signature _____ Date _____

- 3) I agree to the use of my image for medical records **ONLY**.

Patient Signature _____ Date _____