Today's Date: ____/____/____

PATIENT REGISTRATION: COMPLETE ALL ITEMS. PLEASE PRINT CLEARLY

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____
EMAIL ADDRESS	PHARMACY NAME AND ADDRESS		

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

DEMOGRAPHICS

ETHNICITY: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	PREFERRED LANGUAGE:

RACE:
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander
❑ White ❑ Decline

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	SECONDARY INSURANCE NAME	
PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

AUTHORIZATION TO RELEASE HEALTH INFORMATION:

NAME	RELEATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:	DAYSTAR SKIN AND CANCER CENTER staff, have permission to leave messages regarding my medical and/or financial information on my voicemail or cell phone. ❑ Yes ❑ No

Release the following information:
❑ All Records ❑ Chart Notes ❑ Pathology Reports ❑ Operative Reports ❑ History

RELEASE OF INFORMATION

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	Relationship to Patient

Today's Date: ____/____/____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	DATE OF BIRTH

REASON FOR TODAY'S VISIT:

Allergies

❑ NONE/No Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Sulfa Drugs ❑ Iodine ❑ Latex ❑ Penicillin

OTHER:_____

Have you ever had dental anesthesia (Novocaine)? ☐Yes ☐No **Any bad reaction?** ☐Yes ☐No

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING
Skin Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

Immunization – Please indicate if you have had any of the following administered and if known list the date.

Flu Shot	☐Yes	☐No	MM/YY _____
Shingles	☐Yes	☐No	MM/YY _____
Whooping Cough	☐Yes	☐No	MM/YY _____
Pneumonia	☐Yes	☐No	MM/YY _____
Tetanus	☐Yes	☐No	MM/YY _____

SOCIAL HISTORY

Occupation: _____ ☐ Retired ☐ Disabled

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently Do you use IV drugs? ☐Yes ☐No

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) If yes, when did you start? _____

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE

Have you ever been exposed to HIV (AIDS)? ☐**Yes** ☐**No**

(Women) Are you pregnant? ☐**Yes** ☐**No** Due Date _____/_____/_____

Have you ever had skin cancer? ☐**Yes** ☐**No**

Do you have a history of any specific skin disease? ☐**Yes** ☐**No**

If yes, _____

Do you have problems healing? ☐**Yes** ☐**No**

Do you develop keloids (scars) after surgery? ☐**Yes** ☐**No**

Do you bleed easily? ☐**Yes** ☐**No**

Do you use sunscreen? ☐**Yes** ☐**No**

Medical History: Have you ever had any of the following? ❑ **NONE of the problems listed**

LUNGS:
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Morning Cough
- ❑ Shortness of Breath
- ❑ Wheezing

Cardiovascular:
- ❑ High Blood Pressure
- ❑ Chest Pain
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Irregular Heartbeat
- ❑ Phlebitis
  - ❑ Inflammation of Vein
  - ❑ Blood Clot

Other Systemic:
- ❑ Diabetes
  - ❑ Excessive thirst/hunger
  - ❑ Amputation
- ❑ Thyroid Problem
- ❑ Kidney Problem
  - ❑ Dialysis
- ❑ Bladder Problem
  - ❑ Frequency/Burning
- ❑ Convulsion, Epilepsy, Seizures, or Fainting
- ❑ Gastrointestinal Problems
  - ❑ Stomach

When taking antibiotics:
- ❑ Nausea, vomiting, diarrhea
- ❑ Yeast Infection

- ❑ Arthritis/Joint Deformity
  - ❑ Arthralgia
  - ❑ Limited Motion
  - ❑ Artificial Joint

Medications: List any medications you are currently taking: **PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE**

Financial Policy

Thank you for choosing DayStar Skin and Cancer Center for your medical care. We appreciate that you have entrusted us with your healthcare and we are committed to providing you with the best patient care possible.

Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals and/or pre-authorizations. You should be knowledgeable of any deductibles, copayments and/or coinsurance.If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket expenses, and coverage limits.

Insurance Coverage

Please provide us with your current insurance card at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy and keep on file for our records.

Please be aware of and provide any required referrals or authorizations in advance of the appointment. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.

Our doctors belong to many insurance plans. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care. We will help you find out if you have out-of-network benefits and submit a claim to your plan on your behalf.

Co-payments/Co-insurance/Deductibles

You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service. We accept cash, personal checks, VISA MasterCard, and Discover.

Other Bills

You may receive Pathology services during your visit and there will be additional charges for these services.

Self-Pay

Self-pay patients are required to pay **100%** of the estimated amount due at the time of service.

Non-Medical Fees

Additional fees may apply to the following:
Returned Checks – There will be a $25 fee assessed on returned checks.

Missed Appointments – We require a 24 hour notice of appointment cancellation. Appointments missed that are not previously cancelled will be charged a fee of $25.

Late Arrivals - A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may be rescheduled.

Assignment of Benefits and Responsibility to Pay

I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance to issue payment directly to Daystar Skin and Cancer Center for medical services to myself and/or my dependents. I have also read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Print Name of Patient	Signature of Patient (or responsible party)	Date

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient

_____ ___/___/___
Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____
Printed Name – Practice Representative

_____ ___/___/___
Signature Date