Draper DERMATOLOGY
The art and science of skin care

Patient Registration Form

PATIENT INFORMATION (Please Print)

Patient's Legal Name: (Last)_____ (First)_____ (MI)_____

Address:_____

City:_____State: _____Zip:_____

Home Phone:_____ Cell Phone: _____Work Phone:_____

Email Address:_____

Patient's Social Security Number:_____

Preferred Method of Contact: ☐Text ☐Phone Call ☐Email

Patient's Date of Birth: MM_____ DD_____ YYYY_____ Gender: ☐Male ☐Female

Primary Care Provider: _____

Employment: ☐Not Employed ☐Employed Employer:_____

Emergency Contact Name: (Last)_____(First)_____

Relationship to Patient:_____ Phone Number: _____

Marital Status: ☐Single ☐Widowed ☐Married Name of Spouse:_____

Do we have permission to discuss financial/appointment information, biopsy or other test results, or upcoming/missed appointments with a member of your household? ☐Yes ☐No

If yes, whom:_____ Relationship to Patient: _____

Do you have health insurance? ☐Yes ☐No Name of Plan:_____

Policy Holder Information

Name: (Last)_____ (First)_____ (MI)____

Date of Birth: MM _____DD _____YYYY_____ Relationship to Patient:_____

Address: _____

Name of Preferred Pharmacy: _____

Location/Address:_____ Phone Number: _____

CONSENT FOR TREATMENT

I am voluntarily seeking medical care and hereby consent the medical treatment, procedures, laboratory tests, and other health care services provided or referred by Larry E. Urry, M.D. or any other medically credentialed provider(s) under the direction of Draper Dermatology. This agreement will remain in effect until I choose to revoke it in writing.

Patient or Parent/Legal Guardian Signature: _____Date:_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Draper Dermatology's privacy policy.

Patient or Responsible Party Signature: _____Date: _____

NOTIFICATION OF APPOINTMENTS/TREATMENT/UPDATES

Draper Dermatology makes every effort to use your preferred method of communication for billing/appointment/treatment reminders or any issues regarding your account and service. We will update your patient portal with any and all biopsy results, as well as other appointment/billing/treatment updates. Contact with you will be limited and may be made using the information you have provided. Every effort will be made to respect your requests. We DO NOT share your information with third part businesses.

MEDICAL INFORMATION RELEASE TO ASSIGNED PARTIES

In my absence, I authorize Draper Dermatology to release all or portions of my, or my dependents, medical record(s) to those indicated below (i.e. lab results, prescriptions, etc.). This authorization is in effect until I revoke it in writing. Please consider others who may bring your children in for care, such as a relative or guardian.

Name: _____Relationship: _____Phone:_____
Name: _____ Relationship: _____ Phone:_____

Patient or Parent/Legal Guardian Signature: _____Date:_____

CREDIT AND FINANCE POLICY AND AGREEMENT

I agree to be financially responsible for all medical and/or aesthetic bills that result from services rendered by individuals employed by Draper Dermatology on my, or my dependent's, behalf. If medical claims are submitted to an insurance company by Draper Dermatology on my behalf, **I understand that the copayment or deductible is due at the time the care is rendered.** I hereby authorize any benefits due to me to be paid directly to Draper Dermatology (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third-party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

I understand and agree that patients without insurance and/or using cash-pay services are to pay in full upon checkout on the day of service. All delinquent accounts will be charged an interest rate of 13% per annum (1.0833% per month) or a minimum of $0.65 monthly finance charge, whichever is greater, which is due and payable upon receipt of statement. **In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 33% of the unpaid balance.** In the event of a lawsuit, to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney's fees in addition to the collection fee.

I authorize Draper Dermatology to call me at any number I provide or at any number that Draper Dermatology reasonably believes we may contact you (including calls to mobile, cellular, or similar devices) for any lawful purpose. I agree to pay any fee(s) or charge(s) that I may incur for incoming calls from Draper Dermatology, and/or outgoing calls to Draper Dermatology, to or from any such number, without reimbursement from Draper Dermatology.

There is a 24-hour cancellation notice required for all appointments. Draper Dermatology reserves the right to charge $50 for a missed office visit, $100 for a missed surgery appointment, and up to $150 for a missed hair removal, facial, peel, laser, or other medical or aesthetic appointment.

Patient or Responsible Party Signature: _____Date: _____

MEDICAL HISTORY – All information is strictly confidential

Please check any of the following that apply

- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Other _____
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Please explain any items that are marked, unless self-explanatory: _____

_____

_____

SURGICAL HISTORY ☐ NONE

Procedure	Year	Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____

SKIN DISEASE HISTORY – Please check any of the following that apply

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other: _____
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

HISTORY OF MELANOMA

Do you have a family history of melanoma or non-melanoma skin cancer? ☐ YES ☐ NO

If yes, which relatives? _____

_____

HEALTH HABITS – Check which substances you use and describe how much you use.

☐ Caffeine: How Much_____ Yrs_____ ☐ Drugs: How Much_____ Yrs____

☐ Alcohol: How Much_____ Yrs_____ ☐ Tobacco: How Much_____ Yrs____

☐ Marijuana: How Much_____ Yrs_____

ALLERGIES – List any allergies and your reaction ☐ NONE

_____ _____

_____ _____

_____ _____

MEDICATIONS – List prescription and non-prescription medications you are currently taking

Medication_____ Dose_____ Frequency_____

Medication_____ Dose_____ Frequency_____

Medication_____ Dose_____ Frequency_____

Medication_____ Dose_____ Frequency_____

Medication_____ Dose_____ Frequency_____

Medication_____ Dose_____ Frequency_____