Farmington Valley Dermatology & Surgery, LLC

Patient Registration Form

Patient Information: ***Please use ink when completing this form***

Patient' Legal Name: _____ Preferred Name:_____
First MI Last

Home Address:_____
Street City State Zip

Email Address:_____ Occupation:_____

Sex: M F Social Security #: _____ Birthdate: _____

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

Emergency Contact: _____ Relationship_____ Phone#_____

Primary Care Doctor:_____ City:_____State_____

Referring Doctor: _____ City:_____State_____

FVDerm has permission to: 1) Leave Message on: Home / Work / Cell 2) Send Text Message YES / NO

Would you like to be contacted regarding Specials, offers, events? Text / Phone / Email

How did you hear about our office: _____ Are you interested in a cosmetic consult? Yes/No

Primary Insurance Name: _____ Subscriber Name:_____

Relation to Patient: Self Spouse Dependent Other Birthdate:_____

Secondary Insurance Name: _____ Subscriber Name:_____

Relation to Patient: Self Spouse Dependent Other Birthdate:_____

Notice of Privacy Practices: (If the patient is a minor a separate form is required)

A Notice of Privacy Practices has been provided to me from FVDerm. Signature_____
(A copy is located at our front desk for your convenience)

Do you give our office permission to discuss your medical information with family member? ____Yes _____No

Name:_____Relationship_____Phone #_____

Name:_____Relationship_____Phone #_____

Financial Agreement:

I certify that the information I provided is correct. I authorize the release of medical information necessary to process claims to insurance companies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to Farmington Valley Dermatology & Surgery, LLC.

I agree to pay any co-payments and any past amounts at the time of service. Payments can be made in the form of cash, check or charge card. A fee will apply for each returned or NSF check. I understand that if my account is in default, an appointment will not be made until my account becomes current. Also, I will be responsible for any cost associated with collecting a past due debt. Your signature below signifies your understanding and willingness to comply with these policies.

I understand that my insurance is a contract between my insurer and myself. Claim submission provided by Farmington Valley Dermatology is a courtesy. I am responsible for understanding the terms of my policy, including deductibles, co-pays, coinsurances and referrals. I am responsible for obtaining any required referrals or prior authorizations, and in absence of such, I will be held responsible for the cost of service provided.

_____ _____
Your Signature Today's Date

Name:_____ **Date:**_____

Primary Care Physician:_____ City:_____ State:_____

When was your last visit to your Primary Care Physician? Month/Year_____

Referring Physician:_____ City:_____ State:_____

Past Medical History:

	Yes	No		Yes	No		Yes	No
Anxiety	Y	N	Depression	Y	N	Hypothyroidism	Y	N
Arthritis	Y	N	***Diabetes***	Y	N	Leukemia	Y	N
Asthma	Y	N	End Stage Renal Disease	Y	N	Lung Cancer	Y	N
Arterial fibrillation	Y	N	GERD	Y	N	Lymphoma	Y	N
Bone Marrow Transplantation	Y	N	Hearing Loss	Y	N	Prostate Cancer	Y	N
BPH	Y	N	***Heart Disease***	Y	N	Radiation Treatment	Y	N
Breast Cancer	Y	N	Hepatitis A B C (circle)	Y	N	Seizures	Y	N
Colon Cancer	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
COPD	Y	N	HIV/AIDS	Y	N	Other:_____	Y	N
Coronary Artery Disease	Y	N	Hyerthyroidsim	Y	N	NONE	Y	N

Past Surgical History: (please list all)_____

_____

Past Skin History

Acne	Y	N	Dry Skin	Y	N	Poison Ivy	Y	N
Actinic Keratosis	Y	N	Eczema	Y	N	Precancerous Moles	Y	N
Asthma	Y	N	Flaking or Itchy Scalp	Y	N	Psoriasis	Y	N
Basal Cell Skin Cancer	Y	N	Hay Fever	Y	N	Squamous Cell Skin Cancer	Y	N
Blistering Sunburns	Y	N	Melanoma	Y	N	Other:_____	Y	N

Do you wear sunscreen?	Y	N	If yes, what SPF?
Do you use a tanning salon?	Y	N	
Family History of Melanoma? Mother Father Sister Brother Daughter Son Other			

Current Medications:

Name	**Dose/Pill**	**# and type**	**# times per day**
Example: Ibuprofen	*200mg*	*2 tablets*	*3 times a day*

Name:_____ **Date:**_____

Pharmacy Name: _____ **Street:**_____ **City:**_____

Mail Order Pharmacy:_____

❑ I allow Farmington Valley Dermatology to access my prescription history from healthcare providers and pharmacies.

Allergies to Medications: (specify type of reaction, example: anaphylaxis, rash, GI upset, etc…)

_____

Other Allergies:_____

Cigarette/Tobacco Use: Daily Less Than Daily Quit: When: Never (Please circle)
Did you receive the flu vaccine this flu season? Yes No (October thru March)
Have you ever received a pneumonia vaccine? Yes No
Do you have a Health Proxy? Yes No

Current Medical History:

PRIMARY			Night Sweats	Y	N
Immunosuppression	Y	N	Bloody Urine	Y	N
Hay Fever	Y	N	Sore Throat	Y	N
Rash	Y	N			
Changing Mole	Y	N	ALERTS		
Healing Problems	Y	N	Premedication prior to procedures	Y	N
Scaring Problems (Keloid/Hypertrophic)	Y	N	Allergy to Adhesives	Y	N
Bleeding Problems	Y	N	Allergy to topical antibiotic ointments	Y	N
Thyroid Problems	Y	N	Allergy to lidocaine	Y	N
Wheezing	Y	N	Allergy to Latex	Y	N
Shortness of Breath	Y	N	Blood Thinners	Y	N
Cough	Y	N	Currently Pregnant	Y	N
Headaches	Y	N	Planning a Pregnancy	Y	N
Seizures	Y	N	Currently Breast Feeding	Y	N
Blurry Vision	Y	N	Pacemaker	Y	N
Chest Pain	Y	N	Defibrillator	Y	N
Abdominal Pain	Y	N	Artificial Joints within the past years	Y	N
Bloody Stool	Y	N	Artificial Heart Valve	Y	N
Join Aches	Y	N	Rapid Heartbeat with epinephrine	Y	N
Neck Stiffness	Y	N	GI Upset with Antibiotics	Y	N
Muscle Weakness	Y	N	Swollen Lymph Nodes	Y	N
Anxiety	Y	N	Yeast Infection with Antibiotics	Y	N
Depression	Y	N	MRSA	Y	N
Unintentional Weight Loss	Y	N	HIV/AIDS	Y	N
Fever/Chills	Y	N	Hepatitis A B C (please circle type)	Y	N