New healthcare laws require ALL of the below *Patient Registration* information be completed. Thank you.

PATIENT REGISTRATION

Patient's Name (please print clearly)_____
(First) (Middle Initial) (Last)

Address_____Zip Code_____
(Street) (City, State)

Home phone (_____) _____ Work phone (_____) _____ Cell phone (_____) _____

Pharmacy Name & Town_____ Your *Primary Care Doctor* _____

Sex: Male___ Female___ Date of Birth_____/_____/_____ Social Security No. of ***Patient*** _____-_____-_____

_____ _____ _____
(Marital Status) (*If this applies*) Referred by (Name of Physician, friend, or relative) (*Patient's* **email** address)

RACE (*check one*):
( ) White
( ) Black/African-American
( ) American Indian/Alaska Native
( ) Native Hawaiian/Other Pacific Islander
( ) Asian
( ) Other
( ) Patient Declined/Unknown

ETHNICITY (*check one*):
( ) Spanish/Hispanic Origin; or
( ) Not of Hispanic Origin
( ) Patient Declined/Unknown

LANGUAGES SPOKEN (*please list*):
Preferred language_____
Secondary language_____

If the Patient is a *minor* (less than 18 years old)

Name of Parent (or Guardian)_____ Address_____

Parent (or Guardian) **Home** phone (____) _____ **Work** phone (____) _____ **Cell** phone (____) _____

PRIVACY INFORMATION

1. Our office has instituted steps in order to comply with federal *HIPAA regulations* that protect patient health information and privacy. We have a written "***Notice of Privacy Practices***" available for your review.
2. When you return this form to the receptionist, ***you will be asked to sign that you have been provided with this "Notice of Privacy Practices".***
3. In order to confirm your ***Appointments*** and provide you with your ***Medical Information***, we may try to contact you by: calling you at home, at work, or on your cell phone; leaving a message with another person; sending reminder cards or information by mail or email. **In the space below, please list any *restrictions* on the ways in which we may contact you regarding your *Appointments* or *Medical Information***. (Leave blank if none.)

HIPAA contact *restrictions* and/or instructions:_____

_____

_____

_____

Your Name_____ **Reason for today's visit (*chief complaint*):** _____

PATIENT'S HISTORY

Do you currently, or have you in the past, had problems with any of the following (please check):

___ Allergies
___ Arthritis/Muscles/Joints
___ Blood/Bleeding Disorders
___ Cancer
___ Diabetes
___ Ear/Nose/Throat/Mouth
___ Eyes
___ Headaches/Seizures
___ Heart Disease
___ High Blood Pressure
___ Immunologic (incl. Hay Fever)
___ Kidneys
___ Liver
___ Lungs (incl. Asthma)
___ Psychological Disorder
___ Stomach/Bowel
___ Thyroid

Skin Problems
___ Eczema
___ Melanoma skin cancer
___ *Non-melanoma* skin cancer
___ Psoriasis
___ Other skin problems (*list here*):
_____

*** FEMALES:** Are you currently *pregnant*? YES ___ NO ___ Are you planning to become pregnant shortly? YES ___ NO ___

Other Health Problems	Prior Surgeries (list)	

MEDICATIONS CURRENTLY TAKING		SOCIAL/PERSONAL HISTORY
DRUG NAME	DOSAGE	Do you smoke? YES ___ NO ___
		Do you drink alcohol? YES ___ NO ___
		Do you use recreational drugs? YES ___ NO ___
		Occupation: Hobbies:
		Name of Spouse (if married):

ALLERGIES (list all; including allergies to medicine)		

****YOUR *HEIGHT*:**_____
****YOUR *WEIGHT*:**_____

	FAMILY MEDICAL HISTORY - Check box if YES									
	YOUR FATHER	YOUR MOTHER	SIBLINGS 1	SIBLINGS 2	SIBLINGS 3	SIBLINGS 4	CHILDREN 1	CHILDREN 2	CHILDREN 3	CHILDREN 4
Allergies										
Arthritis/Muscles/Joints										
Blood/Bleeding Disorders										
Cancer (*list what types*)										
● Melanoma skin cancer										
● Non-melanoma skin cancer										
Diabetes										
Ears/Nose/Throat/Mouth										
Eyes										
Headaches/Seizures										
Heart Disease										
High Blood Pressure										
Immunologic (incl. Hay Fever)										
Kidneys										
Liver										
Lungs (incl. Asthma)										
Psychological Disorder										
Skin Disease (eczema, psoriasis, etc)										
Stomach/Bowel										
Thyroid										
Other (*specify*)										

Coastal Dermatology, P.C.
55 Willow Street
Mystic, CT 06355

Daniella Duke, M.D.
(860) 245-0000 TEL
(860) 245-0610 FAX

FINANCIAL RESPONSIBILITIES OF PATIENT

1. I understand that I am financially responsible for all services rendered.
2. **At every office visit**, **I will present the Check-In receptionist my most recent insurance card that contains accurate and up-to-date insurance information – so that a copy can be made for my file.**
3. **Late Cancellation Fee**: I understand that your office requires at least **24 - 48 hours advance notice** for canceling or changing an appointment, and that if I fail to give the required notice, ***then a late cancellation fee will be charged***. **For Monday appointments, I understand that I need to cancel or make changes by 12:00 Noon on Friday**.
4. I understand that if this office participates with my insurance, then this office will bill my insurance company. I understand that I am responsible for: the co-pay (at the time of the visit); the yearly deductible; any co-insurance; non-covered services; and cosmetic services. A late fee of 1½% per month will apply for accounts over 30 days late. You will not be balance billed for covered services.
5. I understand that if this office does not participate with my insurance, or if I do not have health insurance, then I am responsible for payment in full upon completion of the visit. As a courtesy, we may agree to bill your insurance company first, and await their payment, before billing you for any balance due. Generally, this exception is for expensive surgical procedures. Payments made by insurers we do not participate with, for less than the full amount billed, are not considered payment in full, and you would be responsible for the remaining balance.

It has been explained to me that Coastal Dermatology, P.C. (Dr. Daniella Duke) is NOT an authorized TRICARE Provider. I understand that I will be solely responsible for the bill, and that neither I nor Coastal Dermatology, P.C. will submit a claim for the services provided by Coastal Dermatology, P.C to TRICARE. Despite Coastal Dermatology, P.C.'s status as a Non-Authorized TRICARE Provider, I choose to receive medical care from them.

6. I understand that if I am covered under a gatekeeper or capitated plan, then I need to obtain a referral from the doctor my insurance plan designates as my primary care doctor (internists, family practitioners, and pediatricians) – and our office needs to obtain the referral ***before my visit***. It is my responsibility to make sure this referral is current and complete. If your insurance plan requires a referral, and you have ***not*** obtained one, you have several options:
   a. Call your primary care doctor and have them give you the required referral.
   b. Reschedule today's appointment until you have obtained the referral.
   c. Pay for the visit today, and submit the claim to your insurance company yourself.
7. I understand that if my secondary insurance doesn't apply (for example, if the secondary insurance requires a referral and one has not been obtained), then co-payments and/or annual deductibles are due upon completion of the visit.

I have read and understood the above policies and obligations, and agree to them for all office visits, including future ones:

You will sign this form electronically in the office
Signature of Patient (or Parent/Guardian)

- -

ASSIGNMENT OF BENEFITS

For services rendered by Coastal Dermatology, P.C., I hereby assign all medical and/or surgical benefits to which I am entitled, including major medical benefits, to: Coastal Dermatology, P.C., 55 Willow Street, Mystic, CT 06355. This includes Medicare, private insurances, and other health plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be valid as an original. I hereby authorize Coastal Dermatology, P.C. to release all information necessary to secure payment.

You will sign this form electronically in the office
Signature of Patient (or Parent/Guardian)

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