CENTRAL MINNESOTA
DERMATOLOGY

Adult Registration

To ensure that we have created your account correctly, please supply the following information.

Please print clearly and circle applicable options

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

DOB: _____ **Gender:** Male / Female

Marital Status: Single / Married / Widowed / Divorced

Social Security #: _____

Race: White / Native American / African American / Hispanic / Asian / Hawaiian / Other: _____

Ethnic Group: Non-Hispanic / Hispanic / Decline

In the event of an emergency who would you like us to contact?

Spouse Name: _____

Phone Number: (_____) _____

Other or Additional Emergency Contact:

Name: _____

Phone Number: (_____) _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Which city would be your preferred location for future appointments? Brainerd / Little Falls / Pine River / Verndale

Preferred Phone Number: (_____) _____ Mobile or Landline

Alternate Phone Number: (_____) _____ Mobile or Landline

Email Address: _____

Employer: _____ **/ Unemployed / Retired**

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Financial Policy and Consents Form

Thank you for trusting Central Minnesota Dermatology with your skin care needs. We are committed to providing you with the best possible medical care. We ask that you review our Financial Policy, as a clear understanding of our practice financial policy is key to our professional relationship. This information is provided to avoid any confusion related to payment and appointment reservation for professional services. Your signature below shows your understanding and willingness to comply with our policy.

***Insurance:** At each visit, we will verify your current insurance. If we are unable to verify your insurance, you will be expected to pay at the time of service. We will assist you in submitting claims. Any patient balance determined by your insurance as well as any uncovered portion of your bill is your responsibility.

***Co-payment:** Co-payments are determined by your insurance. All co-payments are collected at the time of the visit.

***Missed Appointments and Late Cancellations:** Missed appointments represent a cost to us, you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please notify the office at least 24 hours in advance. Failure to provide 24-hour notice will result in a no-show charge. This charge is not billable to your insurance. The first no-show will not be charged. A second no-show will result in a $25 charge assessed to you. The third no-show will result in a $50 charge and the fourth will result in a $100 charge. If you no-show or cancel your appointment within 24 hours of your appointment for a fifth time, we will discharge you from the practice.

***Referrals:** If your insurance requires a referral from your primary care provider (PCP), it is your responsibility to obtain this prior to your appointment.

***Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the provider and complete all necessary forms. A signed authorization from the parent or legal guardian allowing our provider to provide medical treatment is available for subsequent visits. All co-pays are due at the time of each visit.

***Payment of your Bill:** You will receive a monthly statement and payment is due 30 days from the statement date. We accept cash, check or credit/debit cards. You may also pay on-line via the portal or the PocketPatient app. If you are unable to pay the balance in full, please contact our billing office. You are responsible for all fees related to your care. Any remaining balance after 120 days will be sent to a collection agency. Prescription refills and future scheduling will be prohibited until prior balances have been paid. A $25 fee will be assessed for any returned checks.

***Pathology and Laboratory Services:** Some services, such as blood work, cultures and tissue biopsy/excisions are sent to an outside laboratory for processing and evaluation. Billing for these services will be handled by these outside providers. We will send your insurance information with the specimen(s) and will make every effort to send them to providers that are in-network with your insurance plan, but this cannot be guaranteed.

***Assignment of Benefits:** I hereby assign payment of authorized medical benefits to Central Minnesota Dermatology for services furnished to me by providers of that entity. I authorize the release of medical information necessary to determine that benefits are payable for the services rendered. I understand that I am financially responsible for all charges not paid by insurance and that copays are due on the day of service as required by my insurance carrier. Central Minnesota Dermatology does not deny service based on age, gender, race, ethnicity, disability, religion, or political belief. If you feel you have been discriminated against you may file a complaint with the Clinic Administrator without any risk of penalty.

***Third-Party Reminder:** By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my provider, the time and place of my scheduled appointment(s), and other limited information, for the purposes of notifying me of a pending appointment or other notification. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages to be left on my voicemail, answering machine, or with another individual, if I am unavailable at the number provided by me.

***Privacy Practice Notice:** I acknowledge that a copy of the Privacy Practice Notice is available to me upon request.

Name of patient (please print) _____

Signature _____ **Date** _____

Signature of patient or responsible party if under 18 years of age. ****This authorization will remain active until revoked in writing****

1903 South 6th Street, Suite 3 • Brainerd, MN 56401
Phone: 218-454-3376 • Fax: 218-454-4263
www.centralmnderm.com

History and Intake Form

ROI Signed: _____

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

Primary Doctor and Facility: _____ NONE

Pharmacy (include city): _____

Past Medical History: (please circle all that apply)

ADHD	Cirrhosis (liver disease)	Hay fever/seasonal allergy	Neuropathy
Anxiety	COPD	Hearing loss	Parkinson's disease
Arthritis, rheumatoid	Coronary artery disease	Hepatitis	Radiation treatment
Arthritis, Osteoarthritis	Crohn's disease	High blood pressure	Renal disease
Arthritis, Psoriatic	Dementia	High cholesterol	Seizures
Asthma	Depression	HIV/AIDS	Stroke
Atrial fibrillation	Diabetes	Hyperthyroidism	Ulcerative colitis
Autism	Pre-diabetes	Hypothyroidism	
BPH (enlarged prostate)	GERD	Multiple sclerosis (MS)	None

Have you had any form of cancer? (please circle all that apply)

Breast Colon Lung Prostate Other: _____

Past Surgical History: (please circle all that apply)

Adenoid removal	Hip replacement – right, left	Prostate removal
Appendix removal	Knee replacement – right, left	Spleen removal
C-section	Shoulder replacement – right, left	Tonsil removal
Colectomy	Kidney removal	Transplant – organ or bone marrow
Coronary artery bypass	Kidney stone removal	TURP (prostate resection)
Gall bladder removal	Lumpectomy	Testicle removal – one or both
Heart valve replacement	Mastectomy – right, left	Wisdom tooth extraction
Hysterectomy	Ovary removal – one, both	None

Other: _____

Skin Disease History: (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic keratosis (precancer)	Flaking or itchy scalp	Rosacea
Basal cell skin cancer	Melanoma	Squamous Cell Carcinoma
Blistering sunburns	Poison ivy	Other:
Dry skin	Precancerous moles	_____

Do you wear sunscreen? No ___ Yes ___ If yes, what SPF? _____

Do you tan in a tanning bed? No ___ Yes ___

Do you have a family history of **melanoma** skin cancer? No ___ Yes ___

If yes, which relative(s) _____ (only pertains to first-degree relatives)

PLEASE CONTINUE HEALTH HISTORY INFORMATION ON THE BACK

Medications: Do you currently take any medications or supplements? No ___

Please List All Current Medications and/or Supplements:

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Allergies: Do you have any allergies to medications, foods, animals, or pollen? No ___
If yes, please list all below:

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Social History:

Alcohol Use: none <1 drink per day 1-2 drinks per day 3+ drinks per day socially

How many times in the past year have you had >

-Men: 5 or more drinks a day? _____ times a year

-Women: 4 or more drinks a day? _____ times a year

Cigarette Smoking: never former smoker smokes daily smokes less than daily

Recreational Drug Use: none IV drug use Marijuana use (non-medical)

Quality Measures:

Do you have a health care proxy in place? No ___ Yes ___

Have you ever had the Pneumonia Vaccine? No ___ Yes ___

Have you had the Influenza Vaccine within the last year? No ___ Yes ___

Review of Systems:

Allergy to adhesives	Yes	No
Allergy to lidocaine	Yes	No
Allergy to topical antibiotic ointment	Yes	No
Artificial heart valve	Yes	No
Artificial joints within the past two years	Yes	No
Blood thinners	Yes	No
Defibrillator	Yes	No
Pacemaker	Yes	No
History of MRSA	Yes	No
Premedication prior to procedures	Yes	No
Rapid heartbeat with epinephrine	Yes	No
Pregnant or planning a pregnancy	Yes	No
Breastfeeding	Yes	No
Contraception	Yes	No
Immunosuppressed	Yes	No

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Personal Release- **This is an optional release and can be declined by leaving this form blank.**

PLEASE READ *****HIPAA Privacy Rules mandate that we can only discuss information regarding your account or medical care with YOU, the patient, and your physician. If you would like us to be able to leave or discuss your account information (appointment, financial or medical) with anyone else, they must be added as a personal release on your account. This includes spouse, family, friends, and caregivers.*****

I authorize Central Minnesota Dermatology to be able to leave or discuss my protected health information with the following person or persons.

Personal Release (1):

Name: _____

Relationship: _____ Phone: (_____) _____

Personal Release (2):

Name: _____

Relationship: _____ Phone: (_____) _____

****SIGNATURE: _____ DATE: _____****

I permit a copy of this authorization to be valid in place of the original.

This authorization will remain in place until revoked in writing.

I understand that it is my responsibility to inform Central Minnesota Dermatology of any changes related to this release.

****

TO CANCEL THIS AUTHORIZATION

I hereby revoke the above authorization / authorizations. (To revoke this authorization removes all person or persons listed)

Signature: _____ Date: _____

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