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| https://lh5.googleusercontent.com/3kDdEH5o_XQwY2r2L4BwQ6rK7vZr3cLPcTt68sotS1fZV3aQMH9e6xOEROmxODQd3eHvY1Qcr8tPurvlDZ3L_HA0BkKetCVxSvDlQWUwtz-dYDf6E4RfmNGYi1Wv4tk0p0rXMJs1TbpuNAIZrPxihbAs0y1Kj5RSCHBL_z01QbY5J-3JuXeNGRM6 | **New Patients**Bala DermatologyMary E. Griffin, DO FAAD    One Bala Plaza • Suite 620 • Bala Cynwyd, PA 19004www.baladermatology.com • Phone: 610.664.3300 • Fax: 610.664.1151 |

**Registration Form**

**Name: (Mr., Mrs., Ms., Miss., Dr.)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex**: \_\_\_\_\_\_\_\_ **Marital Status**: \_\_\_\_\_\_\_\_\_\_ **SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Student:**\_\_\_\_\_\_\_\_ Full or Part-time(Circle)

**Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_               **Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you learn about our office (Who referred you)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Information:**

Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber: Self \_\_ Spouse \_\_ Dependent\_\_      SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information:**

Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Subscriber: Self \_\_ Spouse \_\_ Dependent\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY FORM- Complete Every 6 Months** ▢NO CHANGE

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Please list all medications that you are currently taking. ▢ No medications

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Are you allergic to any medication? Please list. ▢ No allergies

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **3. Have you had the flu vaccine this season?** **▢ Yes ▢ No**

**Medical History (**Select any of the following medical conditions that you currently have)

* Anxiety
* Arthritis
* Asthma
* Depression
* Diabetes
* Hearing Loss
* Hepatitis Type: \_\_\_\_\_\_\_
* High Cholesterol
* High Blood Pressure
* Hyperthyroidism
* Hypothyroidism
* Seizures
* Stroke
* Problems with bleeding
* Problems with healing
* Hay fever/other allergies
* Immunosuppression
* Headaches
* Heart problems
* Pregnant
* Kidney/urinary problems
* Artificial Joints(specify joint/year): \_\_\_\_\_\_\_\_\_\_\_
* Shortness of breath
* Heart Attack
* Defibrillator
* Pacemaker
* Implantable Devices
* Other Cancer (Not of Skin): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other (List below) \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Cancer:**

* Basal Cell Carcinoma
* Squamous Cell Carcinoma
* Melanoma

**Family history of:**

**Melanoma:** ▢ Yes ▢ No **Relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Non-Melanoma skin cancer:** ▢ Yes ▢ No **Relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social History: *(THESE ARE GOVERNMENT REQUIRED QUESTIONS)***

1. Alcohol consumption: ▢ Never ▢ Seldom ▢ Occasional ▢ Usually every day (type \_\_\_\_\_\_\_\_\_)

2. Do you use any tobacco products or vape: ▢ Yes ▢ No ▢ Former/Quit

**For Patients 65 years of age and older:**

*1. Do you have a living will? ▢ Yes ▢ No ( If you answered NO, continue to 2nd question)*

*2. Do you have Medical Directive? ▢ Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**For patients 19 years old and under*,* please provide the following:**

Height: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Weight: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BALA DERMATOLOGY**



**Notice of Privacy Practice Patient Acknowledgement**

**Consent for Use and Disclosure**

By signing below, I acknowledge that I have been provided the *Practice Notice of Privacy Practices*, which contains a detailed description of the uses and disclosure of my health information and I have been given the opportunity to read the Notice. I hereby authorize *Bala Dermatology* to obtain, use and disclose private health information about me to carry out treatment, healthcare operations and to secure payment of my insurance carrier (including Medicare, Blue Shield, Personal Choice, Aetna, Major Medical and all other private insurance carriers) I have the right to review the Notice of Practices prior to signing the consent. A copy of the Notice is available upon request. Further, I authorize my insurance carrier to make direct payment to *Bala Dermatology*.

By signing below, I acknowledge the Notice of Privacy Practices.

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date Of Birth**:\_\_\_\_\_\_\_\_\_\_

                  (Print)

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Internal Office Use Only:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

**Individual refused to sign: (please specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presented on: (date and time):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presented by: (name and title):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Covered Information:**

I **give** permission to disclose personal health information to ( Please Circle One):

Spouse Adult Child Parent Sibling Personal Representative

List Names and Phone Numbers of Above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BALA DERMATOLOGY**



**Financial Policy**

*Bala Dermatology* believes that communicating our financial policy is good healthcare practice. Charges incurred for services rendered are the patient’s responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.  **You are responsible for all copays, coinsurance, deductibles, and non-covered services**. **We are obliged to collect your copay at the time of service per your insurance company.**   We accept cash, debit card, check, MasterCard & Visa. Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances – they are applied to the current date of service.. When you receive healthcare services from us and we bill your insurance, it is the same as though we are extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursements by many insurers, including Medicare, we simply cannot afford to carry large balances. Please understand that we cannot waive deductibles, coinsurance and copays that are required by your insurance. This is a violation of our contracts with the insurance plans. **We kindly request at least 48 hours notice for any appointment cancellations, or a fee may be assessed.**   I understand and agree to the *Bala Dermatology* Financial Policy.

**Patient Name (print)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_              **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                         **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_