

New Patient Registration Form

Today's Date: _____

Name: _____**DOB**: _____

Sex: _____ **Marital Status**: _____

Home Address: _____

Cell Number: _____**Alternate Phone Number (□work or □home)**: _____

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

Email Address: _____

Primary Care Physician Name: _____

Phone number: _____Fax Number: _____

How did you learn about our office? □*Radio or TV* □*Philadelphia Magazine* □*Main Line Today* □*Yelp* □*Church Bulletin* □*Google* □*Doctor Referral* □*Patient Referral* □*Word of Mouth* □*Social Media*

***Pharmacy Name*:** _____

Address: _____Phone Number: _____

***1. Primary Insurance* Name**: _____

Subscriber's Name: _____ DOB: _____

Relationship to Subscriber: □**Self** □**Spouse** □**Dependent**

Policy #: _____ Group #: _____

2. Insurance Name: _____

Subscriber's Name: _____ DOB: _____

Relationship to Subscriber: □**Self** □**Spouse** □**Dependent**

Policy #: _____ Group #: _____

Emergency Contact

Name: _____ Relation: _____ Phone: _____

Bala Dermatology

PAST MEDICAL HISTORY FORM (Complete Every Year)

Name: _____ **DOB:** _____

1. Please list all medications that you are currently taking or provide a list ❑ **NO MEDICATIONS**

   _____

   _____

2. Are you on a blood thinner or daily Aspirin? ❑ **NO** / ❑ **YES (please list):** _____

3. Are you allergic to any medication? ❑ **NO ALLERGIES** /❑ **YES (please list):**

   _____

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
- ❑ 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

Are you currently pregnant, suspect you may be pregnant, or planning to become pregnant?

❑ Yes ❑ No ❑ Unsure/Possibly_____

Family history of:

Melanoma: ❑ Yes ❑ No Relative: _____

Non-Melanoma skin cancer: ❑ Yes ❑ No Relative: _____

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

1. 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 ❑ No / Name: _____Phone: _____



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:_____



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: _____

Bala Dermatology

New Patient Consent & Acknowledgment Form

Patient Name: _____ DOB: _____

Consent for Dermatologic Care and Procedures
I consent to evaluation, diagnosis, and treatment by Bala Dermatology, including medical and cosmetic dermatologic care. This may include examinations, biopsies, shave removals, excisions, cryotherapy, injections, minor surgical procedures, laser treatments, cosmetic treatments, and prescription medications as deemed appropriate by my provider. I understand that no guarantees have been made regarding treatment outcomes.

Pathology and Diagnostic Testing Acknowledgment
I understand that when a skin lesion is removed or biopsied, the tissue is routinely submitted for pathology evaluation as part of standard dermatologic care. I acknowledge that pathology services are medically necessary, not optional once tissue is removed, and are billed separately by an independent laboratory.

Cosmetic Services Disclosure
I understand that cosmetic services are elective, self-pay, and not covered by insurance. Fees for cosmetic services are nonrefundable and have been discussed prior to treatment.

Communication Consent
I consent to communication via phone, voicemail, email, patient portal, and text messaging regarding appointments, results, and care coordination. I understand electronic communication is not intended for urgent medical issues.

No-Show and Cancellation Policy
I understand that missed appointments or late cancellations may result in a fee according to office policy.

Photo and Imaging Consent
I consent to clinical photographs for medical documentation and treatment purposes. These images may become part of my medical record and will **not** be used for marketing or publication without separate written authorization.

☐ I consent to clinical photographs and/or imaging

☐ I **DO NOT** consent to clinical photographs and/or imaging

Patient Acknowledgment and Signature:
I have read and understand the information above and agree to the terms outlined.

Patient Signature: _____Date: _____

If patient is a minor:

Parent/Guardian Name: _____ (Please Print Name)

Parent/Guardian Signature: _____Date: _____