MEDICARE PATIENT REGISTRATION FORM

Name: _____ Jr /Sr
First Middle Last (how you wish to be addressed)

Local Address: _____
Street City State Zip Code

Other Address: _____
Street City State Zip Code

Local Phone: ( )_____ Other Phone: ( ) _____

Cell Phone: ( )_____

Social Security #: _____ Date of Birth: _____ Age: ____ Sex: ___ M ___ F

Name of Spouse Or Friend: _____ Phone Number: _____

Do we have your permission to:

Leave a message on your answering machine at home? Y _____ N _____
Leave a message at your place of employment? Y _____ N _____
Discuss your medical condition with any member of your household? Y _____ N _____

If yes, whom: _____ Relationship _____

_____ Relationship _____

Office / Billing Policy: We will file your charges to Medicare and the supplemental insurance. If you do not have supplemental insurance, you will be responsible for 20% of the charges at the time of the visit. You will also be responsible for your 2012 Medicare annual deductible of $140.00. All returned checks are subject to a $30 handling fee.

Medicare Lifetime Authorization: I authorize Dr. King to release to the Social Security Administration and Center for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance be made to Daniel King, MD. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Insured Signature Date

Supplemental Insurance Authorization: I request authorized insurance benefits be made to Daniel King, MD on my behalf for any services furnished to me. I authorized Dr. King to release to the attached insurance carrier any information needed to determine benefits. If payment is not received from the insurance company within 60 day, the account balance will be your responsibility.

_____ _____
Insured Signature Date

I hereby authorize Daniel King, MD to request medical records, pathology reports and laboratory reports from any physician, hospital, or clinic where I have been treated. I also authorize Daniel King, MD to release any medical records, pathology reports, and laboratory reports to any physician, hospital or clinic if requested. I authorize the release of my medical records or other information necessary to process an insurance claim.

_____ _____
Signature Date

MEDICAL HISTORY

Name: _____ Date: _____

Referred/Consulted by (name of person): _____

Primary Care Physician: _____

Has a first degree relative (parent, brother, sister, or child) had a melanoma? Y/N

Do you have a history of …..(circle no or yes, please)

High Blood Pressure	N/Y	Diabetes	N/Y
Irregular or fast heart beat	N/Y	Thyroid problems	N/Y
Emphysema or Asthma	N/Y	Prostate problems	N/Y
Hepatitis	N/Y	Glaucoma	N/Y
Kidney problems	N/Y	Seizures	N/Y
Stomach Problems	N/Y		

Do you have an artificial heart valve? N/Y

Do you have a history of endocarditis (heart infection) or heart birth defect? N/Y

If the answer to either of these questions is "yes," does your cardiologist require antibiotics before surgery? N/Y

If "yes," who is your cardiologist?_____

Artificial Joints N/Y If "yes" How old is your joint? _____

If older than 2 years, does your orthopedist require you to take antibiotics prior to surgery? N/Y

Please list any other health problems or surgeries you have had:

_____

_____

Do you smoke? N/Y - # packs per day _____

Do you drink alcohol? N/Y – frequency _____

Occupation: _____

Medication Allergies: _____

(Women) Are you pregnant N/Y Do you plan on getting pregnant in the next year? N/Y

_____/_____/_____/_____/_____/_____/_____/_____

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_____/_____/_____/_____/_____/_____/_____/_____

Medication List

Including ALL Vitamins and Herbs

(*Affix Label)*

Date	Medication	Start Date	Stop Date	Comments

Daniel King, MD
Dermatology Associates of the Treasure Coast
809 East Osceola Street • Stuart, FL • 34994
Phone: 772 219 0044 FAX: 772 219 0709

What is your main skin concern? Accompanied by: Date:

Where is the area of concern?
How long have you had the problem?
Is the problem getting worse? N/Y
Does it itch? N/Y
Does it hurt? N/Y
How bad is the problem(circle one)? mild moderate severe
How often is it a problem? daily weekly constant
What have you done for it?

List any other problems to be addressed:

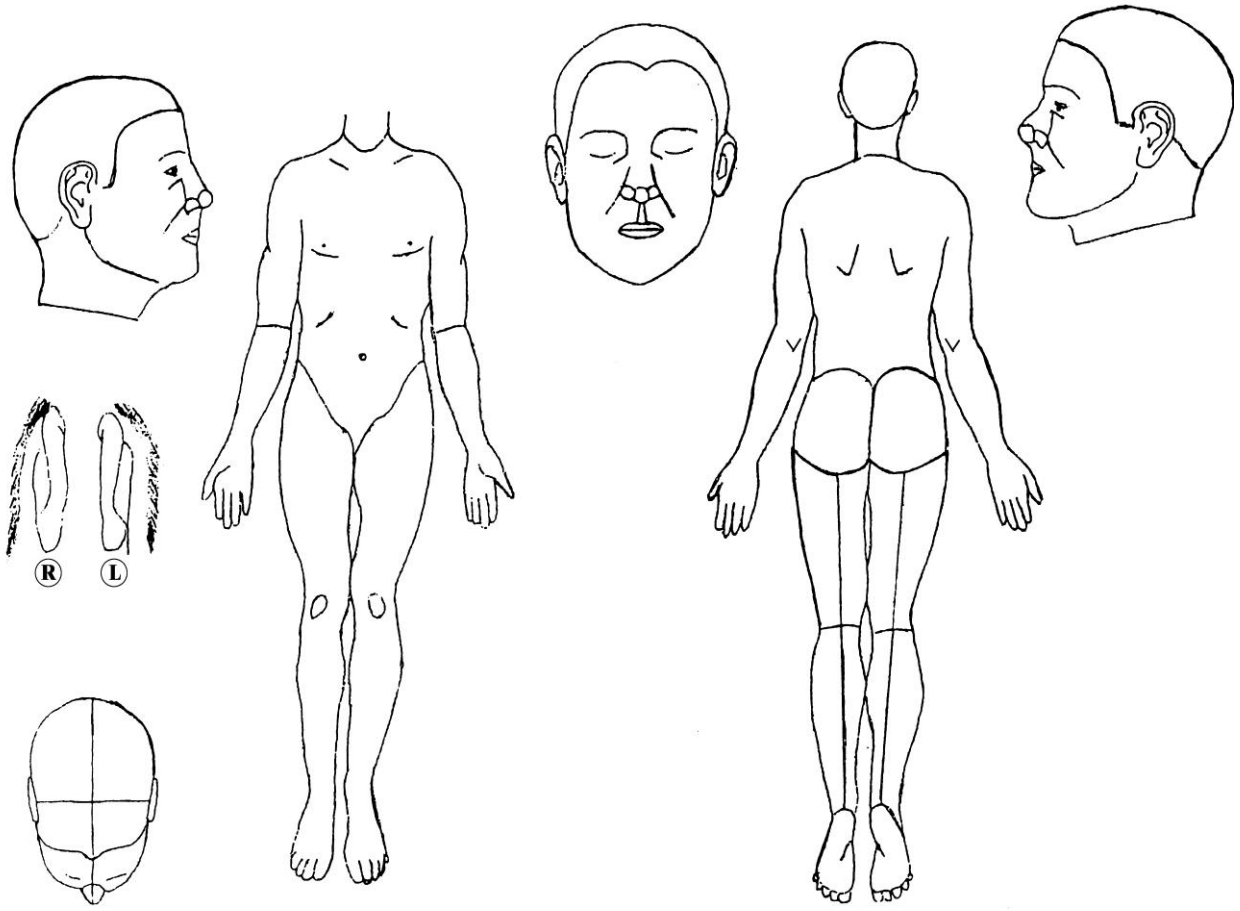
Are any other areas of your body affected by your concerns?

Are there any lesions on your skin or in your mouth that are changing, hurting, itching, or bleeding? N/Y/NA

Have you ever had a skin cancer? N/Y-type/location:

A full skin exam is recommended for skin cancer detection, do you want one? Y/N INT___

OFFICE USE: B/P P no acute distress healthy, frail alert, oriented(person, place, time), inappropriate, uncommunicative pleasant, flat, upset well nourished, thin, obese makeup



E1full
1upper

Accutane
Aldara Sc
Aldara wart
CyroA
Cyst
Dysplstc
Efudex
Efud/Aldara Sc
Follow sites
Fungus/Int
Hair
Hand eczema
H/o SK / B / S
Insect
Meds
MM/ABCDE
Nail
OTC
PDT
Perirectal
Photograph
Pred
Psoriasis
Rosacea
Scabies
Shavng
Scr/Sunsafety
Sginstr
SkinCaRx Opt
Staph
Taper
Urt:AAD
WmCmpr
Wtreat
Wtreatopt
Wound Care

No dictation
Not seen
Seen

Self exam advised

Pre-op chk

1w 2w 3w 1m 6w 2m 3m 4m 6m 12m 30min, 40min, 60min 75min
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
_____I scribed for Dr. King/Sally Ritter, ARNP F/U w/ Dr. King / Sally Ritter, ARNP / MA

Daniel King, MD

Dermatology Associates of the Treasure Coast

Board Certified Dermatologist

Patient Consent for Use and Disclosure of Protected Health Information

Required by U.S. Government Privacy Legislation

With my consent, Dermatology Associates of the Treasure Coast may use and disclose protected health information (PHIL) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dermatology Associates of the Treasure Coast reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology Associates of the Treasure Coast Office Manager at 809 East Osceola St. Stuart, FL 34994

With my consent, Dermatology Associates of the Treasure Coast may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dermatology Associates of the Treasure Coast may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Dermatology Associates of the Treasure Coast may e-mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dermatology Associates of the Treasure Coast restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dermatology Associates of the Treasure Coast's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology Associates of the Treasure Coast may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date