NEW PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION				DATE OF BIRTH
LAST NAME	FIRST NAME		MI	SOCIAL SECURITY#
HOME ADDRESS	CITY		STATE / ZIP	SEX: MALE FEMALE
MOBILE#	HOME#		WORK#	
EMAIL ADDRESS	MARITAL STATUS: ◯ MARRIED ◯ SINGLE ◯ DIVORCED ◯ SEPARATED ◯ WIDOWED			

RESPONSIBLE PARTY INFORMATION (if other than Guarantor)			DATE OF BIRTH
LAST NAME	FIRST NAME	MI	HOME#
ADDRESS ☐ CHECK IF SAME AS ABOVE	CITY	STATE / ZIP	SOCIAL SECURITY
EMPLOYER	OCCUPATION		WORK#
EMPLOYER'S ADDRESS	CITY	STATE / ZIP	RELATIONSHIP TO RESPONSIBLE ◯ SPOUSE ◯ SON ◯ DAUGHTER
FATHER'S NAME(if patient is minor)	FATHER'S BIRTH DATE	MOTHER'S NAME(if patient is minor)	MOTHER'S BIRTH DATE

EMERGENCY CONTACT INFORMATION			
NAME	RELATIONSHIP		PREFERRED #1
ADDRESS	CITY	STATE / ZIP	PREFERRED #2

INSURANCE INFORMATION ☐ PPO ☐ POS ☐ MEDICARE ☐ HMO CO-PAY $			
PRIMARY INSURANCE	SOCIAL SECURITY#	SUBSCRIBER NAME	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER		EFFECTIVE DATE
SECONDARY INSURANCE	SOCIAL SECURITY#	SUBSCRIBER NAME	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER		EFFECTIVE DATE

Would you like to sign up to our InteliChart Patient Portal? ☐ Yes ☐ No [If yes, provide email above]

Patient Signature / Guardian Signature

_____

Today's Date ____/____/_____

MEDICAL HISTORY INTAKE FORM

Last Name: _____ First Name: _____MI: _____

Referred By: _____

Primary MD: _____ City/State: _____

Dermatologic Related Allergies:

☐ Local anesthetic lidocaine ☐ Adhesive Tape ☐ Epinephrine ☐ Latex

Drug Allergies?: _____

Medical Conditions:

☐ Anticoagulant treatment (Coumadin, Warfarin, Eliquis, Aspirin)

☐ Abnormal scars / Keloid scars	☐ Diabetes	☐ Hypertension	☐ Organ transplant
☐ Pacemaker / Defibrillator	☐ Hepatitis	☐ Depression	☐ Thyroid disease
☐ Inflammatory bowel disease	☐ HIV+	☐ Arthritis	☐ Kidney disease
☐ Immunosuppressed	☐ MRSA	☐ Lupus	☐ HSV-cold sores
☐ Artificial heart valve	☐ Eczema	☐ Psoriasis	☐ Other: _____
☐ Hay fever	☐ Asthma	☐ Fainting	

Previous surgeries: _____

Do you have history of Melanoma? ☐ Yes ☐ No

Do you have history of non-melanoma skin cancer? (BCC/SCC) ☐ Yes ☐ No

Current Medications with dose:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy (Name + Location) _____

I hereby authorize the physician or their representative to leave detailed voice message (i.e.: Pathology / Laboratory result) with authorized person.

Self or authorized Person: Name_____ **Relationship_____**

Patient Signature: _____ **Today's Date _____/_____/_____**

Primary Language:
English / Arabic / French / German / Mandarin / Spanish / Other / Decline to answer

Race:
American Indian / Asian / African American / Black / Native Hawaiian / Other Pacific/ White / Unknown/ Other / Decline to answer

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino / Decline to answer

Do you have a family history of melanoma?
Yes, family members(s) affected: _____ / No / Uncertain

Do you have a family history of non-melanoma skin cancer?
Yes, family members(s) affected: _____ / No / Uncertain

Occupation: _____

Do you use tobacco products?	☐ Yes	☐ No	☐ Former User	
Do you drink alcohol?	☐ No	☐ Socially	☐ Moderately	☐ Heavily
Do you use sunscreen?	☐ No	☐ Occasionally	☐ Daily	
Do you use tanning beds?	☐ Yes	☐ No	☐ In the past	
Do you have a history of blistering sunburns?	☐ Yes	☐ No		

Review of Systems (circle if you are reporting that you have related symptoms)

Constitutional	**Eyes/Ears**	**Respiratory**	**GI**	**Hematologic**
Chills	Eye irritation	Cough	Nausea	Bleeding
Fever	Vison changes	Short of breath	Vomiting	Easy bruising
Fatigue	Nose bleed	Chest pain	Diarrhea	Anemia
Weight loss	Mucosal dryness		Abdominal pain	Blood clots
Weight gain				

Endocrine	**Musculoskeletal**	**Skin**	**Neuro**	**Psychiatric**
Swollen lymph nodes	Joint pain	Rash	Dizziness	Depression
Heat/Cold intolerance	Muscle ache	Itching	Headache	Anxiety
Hair loss	Muscle weakness	Acne	Seizures	Memory loss
	Morning stiffness			

FOR WOMEN ONLY:

ARE YOU PREGNANT	☐ YES	☐ NO	☐ UNSURE
ARE YOU BREASTFEEDING	☐ YES	☐ NO	
ARE YOU ON BIRTH CONTROL	☐ YES	☐ NO	
DO YOU HAVE REGULAR MENSTRUAL CYCLES	☐ YES	☐ NO	

First day of your last period: _____

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE NEED

This section I hereby authorize direct payment of all medical and/ or surgical benefits, including major medical, private insurance, and other health plans to Renuka H. Bhatt, MDSC of any medical benefits payable to me for the services provided at Fine Skin Dermatology. I also authorize the release medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted insurance claim processing or as long as dictated by payor. I understand it is my responsibility to pay all deductible amounts, co-insurance, or any co-balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or ineffective.

X

Patient Signature or Signature of Guardian or Parent Date

PATIENT FINACIAL AGREEMENT

This section I hereby authorize the release of pertinent medical information to my insurance carrier; I am aware that I signed up for this health insurance coverage and I am aware that insurances vary, also that insurance carriers may use term such as customary, reasonable prevailing, deductible and out-of-pocket etc. to limit their coverage. I am ultimately responsible, for payment of all charges for services rendered by the providers of Fine Skin Dermatology. As well as other charges for laboratory fees, pathology fees, and any other fees incurred as a result of the treatment rendered to myself of my immediate family. If I have insurance which the doctors are contracted with, I understand that I will be responsible for any co-payments (due at time of visit) deductibles, co-insurance, out of pocket or any procedure that is not considered medically necessary by my insurance carrier.

In the event I fail to pay the balance of my account to Renuka H. Bhatt, MHSC: Fine Skin Dermatology, I hereby agree that if Fine Skin Dermatology forward my account to a collection agency, I will pay the fee charged by the collection agency to Fine Skin Dermatology. In addition, if my account is forwarded to an attorney to undertake legal action to collect the debt, I hereby agree to pay all of the reasonable attorney fees incurred by Renuka H. Bhatt, DBA: Fine Skin Dermatology, in regard to the collection of the unpaid balance. I have also been given a copy of the Office Policy and understand the Office Policy is incorporated by reference and made a part of this agreement.

X

Patient Name Signature of Patient/ Responsible Party Date

PATIENT ACKNOWLEDGMENT OF FINANCIAL RESPONSIBLITY

Due to the rising cost of medical insurance coverage, patients are seeing a rise in their deductibles and out of pocket expenses. Please be aware that you are financially responsible for this portion of your bill and may receive a call to ask for a deposit for any type of procedure. When the office calls you for a deposit, we cannot quote an exact price because all insurance vary with co-pays and deductibles or the percent which you are liable. If your deductible and out of pocket has not been met for the fiscal insurance year, a portion or all of your bill may be applied to the deductible which you are liable. We will file a claim on your behalf to your insurance company through our billing office. You are given an insurance discount at the time the payment is received from your insurance company.
Please do not call our billing office or the doctor for a discount or write off a balance. If you are not sure what your liability is please call the number on the back of your insurance card prior to having any procedures or visits.
We do understand that health issues can causes financial hardship and we are more than willing to work with our patient and set up a monthly payment plan.

Thank you for your understanding in this matter.

X

Patient Name Signature of Patient/ Responsible Party Date

FOR MEDICARE PATIENT ONLY

Please read carefully before signing.

MEDICARE PATIENT ONLY-Lifetime Signature on File and Lifetime Consent I request that payment of authorized Medicare benefits be made on my behalf to Renuka H. Bhatt, MDSC. I authorize any holder of medical information regarding me to be released to the Health Care Fin. Administration and its agents any information needed to determine those benefits or the benefits payable for related service. I request that part of authorized Medigap or secondary insurance benefits be made on my behalf to Renuka H. Bhatt, MDSC.

PATIENT NAME: _____ **SIGNATURE: _____**

DATE: _____/_____/_____

ADDRESSES :-

- **2202 Essington Rd., #101, Joliet, IL 60435 • Phone:** 815.676.5310 • **Fax**: 815.725.1321
- **570 Village Center Dr., #201, Burr Ridge, IL 60527 •Phone:** 630.789.9900 • **Fax:** 630.734.8274
- **10743 W. 159th St., Orland Park, IL 60467 • Phone:** 708.226.0044 • **Fax:** 708.226.0066
- **120 Batson Ct., #201, New Lenox, IL 60451 • Phone:** 815.717.8606 • **Fax:** 815.717.8607

Office Policy

Welcome! We ask that you take a few minutes to familiarize yourself with the following office policies:

Your First Visit
Please bring your insurance card, identification card and a list of current medications. We do request that you bring this information at each visit. If your insurance coverage ever changes, it is important that you let us know and bring your new card.

Minor Patients
All minor patients (less than 18 years of age) must be accompanied by their parent, grandparent or legal guardian on their first visit. Minors under the age of 16 may only be seen with a parent, grandparent or legal guardian. Surgical or laser procedures as well as Accutane related visits must have a legal guardian present if under age of 18.

Contracted PPO and HMO Plans
If our providers are covered in your PPO or HMO plan, any co-payor deductible is due at the time of service and will be collected prior to being seen. The balance will be billed to your insurance. If your HMO requires a referral form from your primary care physician; it is your Responsibility to have this by the day of your visit. If an appropriate referral is not provided, we cannot bill your insurance and you will be fully responsible for the bill at the time of the service.

Missed appointments
If you are unable to keep your appointment, please notify our office at least 48 hours in advance. Failure to provide 48-hour notice will result in a no-show charge. The no-show charge is $50 for appointments Monday-Friday before 5 pm and $100 for appointments 5 pm or later, Saturday and all cosmetic appointments. No show charges are not billable to your insurance.

Self-Pay patients and Non-contracted Insurance
If our providers are not contracted with your insurance plan or you do not have health insurance full payment is due at the time of service.

Bad Debt Account Status
If your account is past due or is placed with our collection agency, we require payment in full prior to scheduling an appointment. Accounts placed with collections will require an additional down payment of $150 prior to a scheduled appointment.

Medicare
Our providers accept Medicare assignment for covered services. All Medicare patients are responsible for their 20% co-insurance and annual deductible and these are due at the time of service.

Financial Responsibility
A $50 charge will be added to your account for any non-sufficient funds notice from the bank. You are responsible for all legal fees including attorney or collection fees if your account is placed in collection.

Non-Covered Services
Cosmetic procedures and other medical services, not covered by your insurance are the patient's responsibility, requiring payment in full at the time of service.

(Signature of Patient or Legal Representative) **Date**