Rockford Dermatology Registration Form

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

Social Security #: _____ Birthdate: _____ Sex: M / F (Circle One)

Marital Status: _____ Occupation/Employer: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Work:_____ Alternate #: _____

Email address: _____

Appointment Notification (Preferred Method): Email Phone (Circle One)

Emergency contact: _____ Phone Number: _____

Primary Insurance: _____ Subscriber:_____ DOB: _____

Secondary Insurance: _____ Subsriber:_____ DOB: _____

Individual we may discuss your care with:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Are you interested in cosmetic non-surgical procedures? (Circle any you are interested in)

Body Contouring Botox Facial Fillers Acne/Sun damaged skin Anti-aging/skin care products

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In order to maintain optimal relations with our patients and avoid misunderstanding or confusion regarding our payment policies, our staff is trained to answer questions regarding our financial policies. Payment is required at the time services are rendered unless valid proof of insurance and billing information are provided and consent signed below.
By signing this consent, I understand that I am giving permission for medical treatment, to perform medical procedures and medically indicated. I also certify that I/my dependent have insurance coverage with the above company/companies, and I sign directly to Dr. LaKimerly Coates all insurance benefits for services rendered.
Further, I understand that (1) minor patients may be asked to reschedule if not accompanied by legal guardian, (2) I may be asked to reschedule if unable to provide accepted proof of insurance and / or payment, (3) Rockford Dermatology has a No Returns Policy on all skincare product purchases, and (4) I may request a full copy of Rockford Dermatology's financial policies or privacy policies at any time.

Signature: _____ Relationship: _____ Date: _____

Witness: _____ Date: _____

Rockford Dermatology History and Intake Form

Patient Name: DOB: Date:

Primary Care MD: _____ **Referring MD:** _____
Preferred Pharmacy: _____ **Preferred Lab:** _____
Primary Language: _____ **Ethnicity: Hispanic/ Latino Not Hispanic/ Latino (Circle One)**
Race: Asian Black/African American American/Native Indian Hawaiian/Pacific Islander White (Circle One)
Emergency Contact: _____ **Phone Number:** _____
***Do you have a surrogate decision maker? Yes No (circle one) Name:** _____
May we leave detailed message? Home Alternate Work (circle one)

Past Medical History: (Please circle all that apply)

Anxiety	COPD	High Blood Pressure	Prostate Cancer
Arthritis	Coronary Artery Disease	HIV/AIDS	Radiation Treatment
Asthma	***Depression**	High Cholesterol	Seizures
Atrial fibrillation	Diabetes	Hyperthyroidism	Stroke
BPH (Large Prostate)	End Stage Kidney Disease	Hypothyroidism	***Height** _____
Bone Marrow Transplant	GERD	Leukemia	***Weight** _____
Breast Cancer	Hearing Loss	Lung Cancer	
Colon Cancer	Hepatitis A B C	Lymphoma	Other: _____

***Vaccinations**: Influenza Pnuemonia Hepatitis C (Please circle all that apply)

Past Surgical History: (Please circle all that apply)

Appendix Removed	PTCA/ Heart Stents	Prostate Removed:
Bladder Removed	Valve Replacement	Prostate Removed: TURP
Breast Mastectomy	Heart Transplant	Rectum
Breast Lumpectomy	Joint Replacement, Knee (Right Left)	Skin: Basal Cell Cancer
Breast Implants	Joint Replacement, Hip (Right Left)	Skin: Squamous Cell Carcinoma
Colectomy: Colon Cancer	Kidney Removed	Skin: Melanoma
Gallbladder removed	Kidney Transplant	Spleen
Coronary Bypass Surgery	Ovaries Removed	Testicles Removed
Hysterectomy	Pregnant (YES NO)	Other:_____

Skin Disease History: (Please circle all that apply)

Acne	Blistering Sunburn	Hay Fever/Allergies	Psoriasis
Actinic Keratoses	Dry Skin	Melanoma	Squamous Cell Skin Cancer
Asthma	Eczema	Poison Ivy	Fever Blisters/Cold Sores
Basal Cell Skin Cancer	Flaking/Itchy Skin	Precancerous Moles	Other: _____

Do you wear sunscreen? Yes ____ No ____ If yes, what SPF ? ____
Do you go to a tanning salon? Yes ____ No ____
Family History of Melanoma? Yes ____ No ____ If yes, which relative? _____
Family History of any Skin cancer? Yes ____ No ____ If yes, which relative? _____

MEDICATIONS : (Include Aspirin, Herbal meds, Vitamins)

_____ _____ _____
_____ _____ _____

ALLERGIES:

_____ _____ _____

***Smoking**: (Circle One) Daily Occasional Never
***Alcohol**: (Circle One) None 1-4 drinks per day greater than 5 drinks per day
Drug Use: Yes ____ No ____
Family History Of: _____ **Family Member:** _____

Do you have a history or are you experiencing any of the following symptoms? (Circle all that apply)

Changing mole(s) Fever/Chill Problems Healing Rash Problems with scarring (keloid)
Problems with bleeding Shortness of breath Immunosuppression Pacemaker Defibrillator
History of fainting Yeast infection with antibiotics GI/Stomach problem with antibiotics
Premedication prior to dental work Joint Aches Thyroid Organ Transplant Taking blood thinners
Allergy to adhesive Allergy to topical antibiotic Allergy to Lidocaine History of Melanoma MRSA
Pregnancy/planning Rapid heartbeat with Epinephrine Other: _____

Are you interest in cosmetic non-surgical procedures? (Circle any you are interested in)
Body Contouring Botox Facial Fillers Acne/Sun damaged skin Anti-aging/skin care products

Reason to see the Dr.: _____

_____ _____ _____
Patient Signature Date Reviewed (Clinical Staff)

ROCKFORD DERMATOLOGY CONSENT FORM

Patient Name: _____ **DOB:** _____

Consent for Treatment: I consent to treatment, diagnostic, therapeutic, cosmetic and surgical services as ordered by the physician and ancillary providers of Rockford Dermatology and her designee(s). I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

I also understand that the laboratory charges are billed separately from the physician and are my responsibility. I understand that I will receive a separate bill from the laboratory that processes my specimen. Rockford Dermatology uses the following lab: Dermpath Diagnostics of Brookfield, Wisconsin. It is your responsibility to advise Rockford Dermatology if your insurance company requires that your labs be sent to a specific pathologist in order to receive full benefits. In the event my doctor deems any procedure medically necessary for my treatment, but the cost is not covered by health insurance, I agree to assume full responsibility for payment.

Consent for Photography: I understand that photographs or digital recordings may be made of me. I understand and agree that the nature of use of these images is for purposes of medical records, consultation and to capture treatment outcomes. The use of medical images for consultation purposes includes sharing of these images with other healthcare providers who are involved in the diagnosis and treatment of my conditions. I have the right to revoke this authorization in writing at any time through a written revocation to Rockford Dermatology.

Patient: _____ Date: _____

Consent for treatment of Minor: I grant my authorization for _____ to represent the minor for care deemed advisable by, and rendered under the general supervision of Dr. LaKimerly Coates and her designee(s) duly licensed where treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

Parent/Guardian signature for patient under 18: _____

FINANCIAL POLICY

Thank you for choosing Rockford Dermatology as your health care provider. We are committed to making your treatment successful. Please understand that timely payment of your bill is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship. Please ask an associate in our billing office if you have any questions about our fees or financial policy.

- **All patients must complete our Registration Form prior to seeing the doctor.**
- **Regarding insured patient, all co-pays and applicable deductibles are due at the time of service.**
- **Regarding patients without insurance, payment in full is due at the time of service.**
- **We accept cash, checks, Visa, Mastercard, Discover and Care Credit.**

Bring your insurance card to every visit and be sure to notify any changes of insurance to Front Desk staff before you are treated. As a courtesy, insurance claims will be prepared and sent to your insurance company on your behalf. Please be aware that some-and perhaps all-of the services provided may be "non-covered" services and not considered necessary under the Medicare program and/or other medical insurance. Insurance is a contract between you and your insurance company. We are not a party to this contract. You are responsible for timely payment on your account. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition, such balances may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fee and /or collection agency's fees and expenses.

Furthermore, if your insurance policy requires a PCP referral for maximum benefit, it is **patient responsibility** to acquire a referral and to verify that we have it on file **prior** to your visit. Otherwise, you may be asked to reschedule.
I, the patient or responsible party, understand that I am fully responsible for all debts incurred as a result of any services rendered. Additionally, deposits may be requested when scheduling procedure appointments **(Surgical or Cosmetic)** that we know are non-covered or non-billable.

Notice of Privacy Practices: I may request a copy from the front desk regarding the Notice of Privacy Practices posted at the front desk. The Privacy Practice describes how Rockford Dermatology may use and disclose my health information, and also describes my rights regarding my health information. By signing this form I consent to Rockford Dermatology using and disclosing my Protected Health Information (PHI) to carry treatment, payment and healthcare operations.

_____ _____ _____

Signature Date Authorized Witness