

PATIENT REGISTRATION FORM

Patients Personal Information

Name: _____ Social Security #: _____

Address: _____ City, State, Zip: _____

Birthdate: _____ Age: _____ Sex: M ___ F ___ Marital Status: _____

Race: _____ Ethnic Group _____ Preferred Language _____

Occupation: _____ Employer: _____

Contact information

Home phone: _____ Cell Phone: _____

Work phone: _____ Email: _____

Emergency Contact

Name: _____ Relationship: _____

Phone number: _____

Pharmacy: _____ Phone number: _____

Address: _____

What is your primary care doctor's name? _____

How did you learn about our office? _____

Insurance Information

Do you have medical insurance? Y N

Primary insurance company: _____

Name of insured: _____ Soc. Sec. No: _____

Your relationship to the insured: _____ Birthdate of Insured: _____

Insured's Employer: _____ Phone: _____

Group Name: _____ Group No.: _____

Secondary insurance company: _____

Name of insured: _____ Soc. Sec. No: _____

Your relationship to the insured: _____ Birthdate of Insured: _____

Insured's Employer: _____ Phone: _____

Group Name: _____ Group No.: _____

PATIENT
SIGNATURE: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Thyroid Problems
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End Stage Renal Disease	Lymphoma
Bone Marrow Transplantation	GERD	Prostate Cancer
Breast Cancer	Hearing Loss	Radiation Treatment
Colon Cancer	Hepatitis	Seizures
COPD	High Blood pressure	Stroke
	HIV/AIDS	
	High Cholesterol	NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:
Currently Smokes
Never smoked
Former Smoker
Date stopped: _____

Alcohol Use:
EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Family History (Only first degree relatives)

ALERTS: (please circle all that apply)

- Allergy to Adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Require antibiotics prior to a surgical procedure
- Rapid heartbeat with epinephrine
- Are you pregnant or currently trying to get pregnant?

**PATIENT CONSENT FOR USE AND
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, Scott Sanders MD, PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). For a more complete description of these uses and disclosures, please refer to the trifold brochure available at the reception desk (Scott Sanders Dermatology, NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES). As a patient, you have the right to review this NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES prior to signing this consent. Scott Sanders MD, PLLC reserves the right to revise its NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES at any time. A revised NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES may be obtained by forwarding a written request to Scott Sanders MD, PLLC Privacy Officer at 301 North Main Street, New City, New York 10956.

I, _____, hereby authorize Scott Sanders MD, PLLC and/or their representatives to release any and all information pertaining to my healthcare, results, and procedures and/or accounting information to the following person(s) or agencies:

Myself

Spouse/Partner, full name: _____

Parent, full name: _____

Other(s), full name: _____ (Relationship)

I further authorize Scott Sanders MD, PLLC and/or his representatives to release results of my medical exams in one or more of the following ways:

May call me (patient) – check all that apply

At home/cell At work May leave a message

On answering machine at home/cell On answering machine at work

With my consent, Scott Sanders MD, PLLC may send by e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations. This includes but is not limited to appointment reminders and patient statements, as long as they are marked "Personal and Confidential."

My preferred email is: _____

I have the right to request that Scott Sanders MD, PLLC restrict how it uses or discloses my protected health information to carry out treatment, payment and health care operations. The practice is not required to agree to my requested restrictions. However, if the practice does agree to those restrictions, it is then bound by this agreement.

By signing this form, I am consenting to Scott Sanders MD PLLC use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I am aware that if I do not sign this consent, Scott Sanders MD, PLLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____ Date _____



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From prior experience we have come to realize the necessity of this statement in order to anticipate some of your questions and concerns and to outline our billing policy. All patients have the opportunity to obtain a copy of this form upon request.

Your Cooperation Is Necessary: Without your cooperation, it is virtually impossible for our office to assure that we are informed of the current, specific requirements of your insurance coverage. This is because our office accepts many insurance plans. From time to time, these plans change their requirements for coverage and the scope of that coverage. A single plan may also differ among individuals. Moreover, deductibles, copays and coinsurances vary with each plan and its prior usage.

Most of Life is Showing Up: Your appointment time has been set aside for you and is unavailable to other patients. Therefore, we require at least 24 hours of advance notice for cancellation. **If you do miss an appointment or cancel with less than 24 hours' notice, you will be billed \$100.00 which must be paid prior to making any other appointments.** Appointment reminder calls are a courtesy which we provide. However, if you do not receive such a call, it is still your responsibility to remember your appointment.

Your Responsibilities: At the time of appointment, it is the responsibility of the patient or guardian to provide our office with whatever documents are necessary for the insurance coverage to be effective. (This is typically just the insurance card and a referral). **It is the responsibility of the patient or their guardian to understand how their insurance plan works. The patient or their guardian should understand that liability for full payment remains with the policy holder.**

When Coverage is Denied: Initial denial of coverage for a procedure by an insurance company is not uncommon. In that case, we will be happy to assist with an explanation of our services for resubmission of claims. If a denial of coverage presents a financial hardship, please discuss this with our office manager, Michelle Medina. Miss Medina is authorized to work with you in order to implement a payment strategy. In unusual circumstances, Ms. Medina will involve Dr. Sanders in these decisions.

Typical Limits of Insurance: Most insurance, including Medicare, cover 80% of total charges. This only takes effect after the deductible has been met. **This practice is NOT expected to absorb your deductible, copays, coinsurance or any other balance of your bill. These are the responsibility of the policy holder.**

If You Do Not Have Insurance: For our patients without insurance, we will charge a flat fee for an initial appointment and for any follow up appointments. These charges are only for the visits. Additional procedures (e.g. biopsies) will have additional fees that will be discussed at the time of the visit and should be paid at that time. For your convenience we accept all major credit cards.

Biopsies: If you have a biopsy or excision, the specimen is sent to an outside laboratory for tissue processing and sometimes for microscopic examination. We use Bio - Reference and Weill Cornell. We will send them your insurance information. Please be aware that you might receive a separate statement from either laboratory since they are a separate entity. If you receive a bill from either laboratory or have questions regarding the charges, please bring it to the attention of our office manager, Michelle Medina.

I HAVE READ THE INSURANCE OFFICE POLICY STATED ABOVE AND UNDERSTAND THAT ANY AMOUNT NOT COVERED BY INSURANCE IS MY RESPONSIBILITY.

Signature of Patient/Guarantor: _____ Date: _____



Scott Sanders, MD
Shilesh Iyer, MD
Elena Maydan, MD
Amy Natalicchio, RN, MSN, FNP-C

**ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION TO THE
ABOVE INSURANCE COMPANIES**

I hereby authorize all medical and/or surgical benefits to Scott Sanders M.D. PLLC. This includes all major medical benefits, Medicare /Medigap, HMO and Government sponsored programs, or any other third-party payor for services rendered to me. I understand that I am responsible for all applicable COPAYMENTS, COINSURANCE AND NON-COVERED SERVICES as required by my insurance policy.

I hereby authorize Scott Sanders M.D. PLLC to release all information necessary, including medical records to secure the payment of insurance benefits.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

MEDICARE ONLY

By signing below, I provide authorization for Medicare to assign benefits to my physician, Scott Sanders M.D. PLLC

SIGNATURE: _____ DATE: _____

OFFICE STAFF (WITNESS SIGNATURE): _____



Scott Sanders, MD
Shilesh Iyer, MD
Elena Maydan, MD
Amy Natalicchio, RN, MSN, FNP-C

Consent for Electronically Accessing Pharmaceutical Information

I, _____ give Sanders Dermatology permission to access and download my medication information from my current pharmacy and enter this information into my medical record at Sanders Dermatology.

The information will be used to evaluate any role that the medications that I am taking may play in my skin and overall health, as well as any possible interactions with medications that maybe prescribed to me by Sanders Dermatology.

The information obtained will be kept completely confidential in accordance with current HIPPA laws and is intended to help my provider maintain the most up-to-date information and provide the safest and most comprehensive care.

Signature: _____

Date: _____