CAROLINA SKIN & VEIN CENTER
1908 Eastwood Rd.
Suite 317
Wilmington, NC 28405

# NEW PATIENT REGISTRATION

Last Name: First Name: MI:

Street Address: Unit #:

City: State: Zip:

Birthdate: / / Age: Gender: (m) (f)

Social Security #: - - Marital Status:

Home Phone #: ( ) - Cell Phone #: ( ) -

E-Mail Address:

Employment Status: (employed) (student) (retired) (other)

Place of Employment:

***Primary Care Provider/Physician***

Name of Physician/Practice:

Street Address: Unit #

Phone #: ( ) - How Often Does This Physician Treat You:

In general, for what does this physician treat you: Last Visit:

***Emergency Contact***

Last Name: First Name:

Relationship to Patient: Phone #: ( ) -

Address:

***Primary Insurance Company:*** _____

***Secondary Insurance Company:*** _____

***Who referred you to Carolina Skin & Vein Center?***

Name:

Contact Phone #: ( ) - May We Thank Them?

*Otherwise, how did you hear about Carolina Skin & Vein Center?* _____

**I CONFIRM THIS INFORMATION TO BE ACCURATE AND I AUTHORIZE DR. LOIS BEARD MARTIN TO TREAT ME AT CAROLINA SKIN & VEIN CENTER**

**SIGNATURE: DATE:**

# PATIENT HISTORY

NAME: _____ SS#: - - M F Date: _____

| YES | NO | HAVE YOU EVER HAD ANY OF THE FOLLOWING: (if yes, please explain) |
|---|---|---|
| ____ | ____ | Reactions or allergies to local anesthetics such as those used by a dentist? |
| ____ | ____ | Bleeding disorders, frequent nosebleeds, easy bruising, or bleeding longer than most people when cut? |
| ____ | ____ | Have you ever fainted? |
| ____ | ____ | Do cuts on your skin heal with normal scars? |
| ____ | ____ | Are you allergic or have you had a "bad reaction" to any substance applied to your skin? |
| ____ | ____ | Have you had previous cosmetic surgery? |

***If you answered "YES" to any of the above questions, please explain…*** _____

_____

_____

***If you answered "YES" for previous cosmetic surgery, please list…*** _____

_____

Name & Address of Local Family Doctor: _____

_____

Name & Address of Local Family Dentist: _____

_____

**Please list the medicines you are now taking *(include birth control pills and vitamins):***

1.) _____ How Long? _____ 2.) _____ How Long _____

3.) _____ How Long? _____ 4.) _____ How Long _____

5.) _____ How Long? _____ 6.) _____ How Long _____

Any Additional Medications/Vitamins: _____

**Allergies to Medicines: ___YES ___NO** ***If yes, please list:*** _____

_____

| Previous Admissions to Hospital/ER: | Procedure: | Year (approximately) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**PLEASE CONTINUE TO PAGE 2**

NAME: DOB: DATE:

**What kind of problem will you be consulting Dr. Martin for today?** _____

_____

_____

**How long has the problem existed?** _____

**Please state the location of the problem:** _____

**Is there anything else you would like to tell us about your past or present medical history?** _____

_____

_____

_____

## REVIEW OF SYSTEMS/SYMPTOMS

**DO YOU HAVE ANY OF THE FOLLOWING:**

1.) Asthma? YES____NO____
2.) Hay fever/seasonal allergies? YES____NO____
3.) History of TB or TB exposure? YES____NO____
4.) History of heart attacks? YES____NO____
5.) High blood pressure? YES____NO____
6.) Night sweats? YES____NO____
7.) Depression? YES____NO____
8.) Seizures? YES____NO____
9.) Hallucinations? YES____NO____
10.) Cancer? YES____NO____
*If yes, which type?* _____
11.) Have you ever had psychiatric help? YES____NO____
12.) Have you ever been unconscious? YES____NO____
13.) Abdominal pain? YES____NO____
14.) History of hepatitis? YES____NO____
15.) Extended muscle pain or weakness? YES____NO____
16.) Arthritis? YES____NO____
17.) Painful urination? YES____NO____
18.) Diabetes? YES____NO____
19.) Thyroid Disease? YES____NO____
20.) Sensitivity to cold? YES____NO____
21.) History of eczema? YES____NO____
22.) History of psoriasis? YES____NO____
23.) History of blood transfusion? YES____NO____
24.) History of intravenous drug abuse? YES____NO____
25.) Have you ever been tested for HIV? YES____NO____
*If yes, when were you tested and what were your results?* _____
26.) Any family history of skin cancer or other cancers? YES____NO____
*If yes, please describe:* _____

_____

**<u>FOR WOMEN ONLY</u>**

1.) Do you have abnormal periods? YES____NO____
2.) Do you have excessive body hair? YES____NO____
3.) Could you be pregnant? YES____NO____

CAROLINA SKIN & VEIN CENTER

Dr. Lois Beard Martin, Dermatologist

*Board Certified in Diseases and Surgery of the Skin, Veins, Hair & Nails*

# FINANCIAL POLICY

Thank you for choosing us as your skin care provider. We are committed to you and the success of your treatment. Please understand that payment, in full, is expected at the time services are rendered. The following is a statement of our financial policy which we request that you read and sign prior to your treatment.

**Insurance**

We cannot bill your insurance carrier unless you bring all necessary information. For those plans with which we participate, (Medicare, BCBS, United Healthcare, and Medcost) all copays and deductibles are expected to be paid at the time of service. Patients with commercial insurance must understand that our medical fees are determined following the same logic used by Medicare in setting their reimbursement. The amount determined by your particular insurance company is a "customary" or "reasonable" fee in no way obligates us to accept this as full payment unless we have signed a contract as a "participating provider". Once you have paid in full, we will be happy to send the proper forms to your insurance carrier to help you receive the maximum reimbursement to which you are entitled.

**Minor Patients**

The adult accompanying the minor (or the parent/guardian) is responsible for full payment of the patient's portion of services rendered. Unaccompanied minors, except emergencies, will be refused treatment unless authorization and payment arrangements have been made in advance.

**Financial Arrangements & Credit Policies**

Payment is expected at the time services are rendered. Any exceptions must be made in advance with the office.

**Cancellation Policy**

We require a *24-hour notice* for cancellation of scheduled appointments. Since we do not double book appointments, it is important that each person keep their scheduled appointment, or provide us with adequate notice so we may use that time for another patient.

***You will be charged $75 for any appointment not cancelled within 24 hours notice.*** Intial_____

I have read this financial policy and agree with it as outlined.

SIGNATURE/PATIENT/RESPONSIBLE PARTY: _____DATE: _____

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government and/or commercial insurance benefits either to myself or to Carolina Skin & Vein Center if accepting assignment.

SIGNATURE/PATIENT/RESPONSIBLE PARTY: _____DATE: _____

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# PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal and medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment, or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must in writing. Under this law, we have the right to refuse to treat you should you chose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____