TRIANGLE DERMATOLOGY ASSOCIATES

Patient Registration

Patient Information

Patient Information:

Last Name:	First Name: M.I.:	Preferred Name:

Mailing Address: Apt #

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Email Address (for appointment reminders):

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work

Date of Birth:	Sex at Birth: ☐ Male ☐ Female	Gender Identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other:_______________	Preferred Pronouns:

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other______________________

Spouse/Partner Name:

Social Security #:

Emergency Contact Name:

Emergency Contact Phone #:

Relationship to Patient:

Responsible Party and Additional Information

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/State/Zip:

Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Race (please select):
☐ White
☐ Hispanic
☐ Other
☐ American Indian or Alaska Native
☐ Black or African American
☐ Decline
☐ Asian
☐ Native Hawaiian or Pacific Islander

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one): ☐ English ☐ Spanish ☐ Sign Language ☐Other:________________________

Primary Care Provider	**Employment Information**
Provider Name:	Employed: ☐ Full Time ☐ Part Time Student: ☐ Full Time ☐ Part Time
Practice Name:	Occupation:
Provider Phone # or Address:	Employer:

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History and Intake

Patient Name: ____ Date of Birth: _______________ Height: _______ Weight: ________

FOR PATIENTS 18 YEARS AND YOUNGER

Preferred Pharmacy: (name, city, address) ____

REASON FOR VISIT: ____

____

Past Medical History: (check all that apply) ***NONE***

Anxiety
Asthma
Bleeding disorder
Depression
Diabetes
Other: ___________

Fainting
Heart valve or heart problems
Hepatitis (if so Type ___)
Herpes/cold sores/fever blisters
High blood pressure

Infections
Kidney problems
Radiation treatments
Seizures
Stroke

Thyroid Disorder
Cancer (other than skin):
____

Skin Disease History: (check all that apply) ***NONE***

Actinic Keratosis (pre-cancers)
Basal Cell Skin Cancer
Other: ____________

Dysplastic (atypical) mole
Eczema
Asthma

Hay fever/Allergies
Malignant Melanoma
Psoriasis

Squamous Cell Skin Cancer
Rosacea

Past Surgical History: (check all that apply) ***NONE***

Appendectomy
Gallbladder
Cataract
C-Section
Other:_____________

Heart Valve replacement
Hysterectomy
Pacemaker
Defibrillator

Organ transplant: __________
Joint replacement: __________

Family Medical History Disease History: *(check all that apply for first-degree relatives and list how family member is related to you)* ***NONE***

Abnormal bleeding
Asthma
Autoimmune Disorders
Eczema

Lupus
Melanoma
Non-melanoma skin cancer
Psoriasis

Skin Disease
Thyroid Disease
Adopted/unknown

Medications: Please list your current prescription and over the counter medications. *You may skip this section if providing a printed list.*

___________________________________ ___________________________________ ___________________________________
___________________________________ ___________________________________ ___________________________________
___________________________________ ___________________________________ ___________________________________

Drug Allergies: ____

Are you allergic to latex? Yes No

Are you allergic to adhesives? Yes No

Cigarette Smoking Never Smoker Former Smoker Current Every day Smoker Current smoker (less than daily)

Alcohol Use None Socially Daily

Recreational Drug Use None Socially Daily

Tanning Bed Use Never Prior Current

Have you had sunburns as a child? Yes No

Are you having any of the following?

Fevers
Chills

Cold intolerance
Heat intolerance

Nausea
Unintentional weight loss

FOR FEMALE PATIENTS:

Are you pregnant or considering becoming pregnant? Yes No

Are you breastfeeding? Yes No

FOR PATIENTS 65 AND OLDER:

Have you received a Pneumonia Vaccination? Yes No

TRIANGLE DERMATOLOGY ASSOCIATES

3008 Pickett Road, Durham NC 27705
P: 919.286.7903
F: 919.286.7151
www.trianglederm.com

Release and Authorization

Patient Name____ Date of Birth_____________

Authorization to Release Health Information

If you would like for us to be able to discuss your medical care with family members, guardians, or caregivers please complete the following:

Triangle Dermatology Associates, PA, is authorized to release protected health information about the above named patient to the entities named below.

Give information to spouse: ____

Give information to family member: ____

Give information to the following person(s): ____

Assignment of Benefits

I hereby authorize payment directly to Triangle Dermatology Associates by my insurance company.

Release of Information

I authorize the release of medical information to my primary care or referring physician, to consultants when necessary and as necessary to process insurance claims, and to obtain prescriptions.

Patient Consent for Use and Disclosure of Health Information

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices dated 9/1/13.

____________________________________ ________________________________ _________________

Patient Name Signature Date

Minors

If the patient is an unaccompanied minor, please fill out the following consent for treatment:

I give my consent for my child_______________________________ to bring themselves to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

____________________________________ ________________________________ _________________

Parent/Guardian's Name Signature Date

Medicare Patients

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Center of 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 benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare card: __________________________________

Medicare Supplement Insurance (Medigap)

If you have a supplemental policy and it is a Medigap policy to which your Medicare Carrier automatically crosses over, we are required to keep a separate signature on file.

I request authorized Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the indicated carrier any information needed to determine these benefits payable for related services.

Signature as it appears on Medigap Card: ____________________________________

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Financial Policy

Thank you for choosing Triangle Dermatology as your healthcare provider. We are committed to providing the best dermatological care possible. The following statement explains our Financial Policy.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor. All patients must be prepared to present verification of identity and current insurance card upon check in.
- All applicable co-pays, unmet deductibles, balances, both current and prior, are due at the time of services.
- We accept cash, checks, Visa, MasterCard, and Discover.
- If you are unable to pay your previous balance or copayment, we may reschedule your appointment.

Regarding Insurance

We participate with several insurance plans and can provide you with a list upon request. For some insurance plans, we accept assignment of benefits, but in all cases, we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under your insurance policy. These charges will be your responsibility. If your insurance plan requires information from you in order to process and pay the claim, it is your responsibility to provide that information to your carrier. If you do not provide information to your insurance carrier in a timely fashion, the entire bill will be your responsibility and due immediately.

Pathology and Laboratory Services

We send patients to LabCorp for lab services. LabCorp will bill your insurance and you directly for their services. When you have a biopsy or procedure, your specimen will be sent to Skin Pathology Associates, and they will bill your insurance and you directly for their services.

Missed Appointments

We ask that you give us a minimum of 24-hour notice if you need to cancel or reschedule your appointment. For patients who routinely miss appointments without calling to cancel, we reserve the right to discontinue the patient/physician relationship.

Statements

We collect at the time of your visit. If you owe an additional amount that was not collected at your visit, we will send you a statement. Payment is due upon receipt. If you have any questions regarding your insurance payment or statement, please call our office at 919-286-7903.

I acknowledge with my signature below that I have received a copy of Triangle Dermatology's Financial Policy and I understand and agree to abide by it.

______________________	______________________	____________
Patient Name	Signature	Date