GREATER KNOXVILLE DERMATOLOGY, PLLC

REGISTRATION FORM

Today's date:	Provider: ❑ Cynthia Kang-Rotondo, MD ❑ Shona Knifley, PA-C ❑ Sarah Beuerlein, FNP-C ❑ Leslie Heller, PA-C ❑ Jamie Roberts, PA-C				
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ❑ M ❑ F
Address:		Social Security no.:		Home phone no.: ( )	
City:	State:	ZIP Code:		Cell phone no.: ( )	
Email:	Employer:			Employer phone no.: ( )	
Parent/Legal Guardian Name:		SS#:		DOB:	
Chose office because/Referred to office by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Website	❑ Other	Spouse's Name:
Medical Doctor & Phone:				Student: ❑Yes ❑ No Name of School:	
Preferred Pharmacy:				Pharmacy Address & Phone:	

Please answer the following questions:

RACE:
❑Caucasian ❑ African-American
❑ Hispanic ❑Non-Hispanic
❑American Indian or Alaska ❑Native
❑Native Hawaiian or other Pacific Islander
❑Asian ❑Care not to answer

ETHINICITY:
❑African-American ❑American Indian
❑Hispanic or Latino ❑Non-Hispanic
❑Caucasian ❑Other ❑Care not to answer

PRIMARY LANGUAGE: _____

Do You Smoke? ❑Yes ❑ No

If yes, how much: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. This office does NOT accept Workman's Compensation. **PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE.** There will be a $20.00 service charge on all returned checks. We accept VISA or MASTERCARD for your convenience. Your signature below indicates that you understand and accept this policy. Your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any) and authorizes payment of medical benefits to the Doctor when an assigned claim filed. Further, you herein authorize release of medical records to referring physician or to medical offices to which we need to refer you. Patients missing appointments, scheduled surgery, or laser procedures may be charged a $25.00 missed appointment fee if adequate notice of cancellation is not given. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____

Patient/Guardian signature *Date*

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MEDICAL HISTORY

Patient: _____ DOB: _____ Date:_____

Reason for today's visit: _____

Medication allergies: YES □ NO □ If yes, list: _____

List all medications you are currently taking: _____

_____

Pharmacy:_____Address:_____Phone:_____

Referring Physician:_____ Phone:_____

Do you have now, or have you ever had diseases or conditions of:

	YES	NO		YES	NO
Bronchitis/Emphysema	□	□	Diabetes	□	□
Asthma	□	□	Blood Clots	□	□
Stomach	□	□	High Blood Pressure	□	□
Bowel	□	□	Chest Pain	□	□
Glaucoma/Cataracts	□	□	Heart Attack	□	□
Kidney	□	□	Irregular Heart Beat	□	□
Arthritis/Joint deformity	□	□	Pacemaker	□	□
Lupus	□	□	Seizures/epilepsy	□	□
Thyroid	□	□	Developmental Delay	□	□
Fainting	□	□	Mental Illness	□	□
Cancer	□	□	Stroke	□	□
What Kind _____			Hepatitis A_____ B_____ C_____		

Other Disease or Condition we should know about: _____
List surgical procedures you have had: _____

Do you drink alcohol? YES □ NO □ If yes _____ drinks per day.
Do you use IV drugs? YES □ NO □ If yes, what _____.
Have you had or have been exposed to HIV (AIDS)? YES □ NO □
Have you ever had dental anesthesia (Novacaine)? YES □ NO □ Any bad reaction? YES □ NO □

Skin: When you are exposed to sun do you: Tan only □ Tan and burn □ Burn □
Have you ever had skin cancer? YES □ NO □
Has anyone in your family had skin cancer? YES □ NO □ If yes, who? _____
Do you have a history of any skin diseases? YES □ NO □ If yes, please list: _____

Do you smoke? YES □ NO □ If yes, how much: _____
Do you bleed easily? YES □ NO □
(Women) Are you pregnant? YES □ NO □ If yes, due date: _____
Do you have artificial joint(s)? YES □ NO □ _____
Who is your employer? _____
What are your hobbies? _____

Completed by: Patient Other _____ Medical Assistant (Initial) _____

Physician Signature: _____ Date: _____

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Consent for Healthcare Messages

Patient Name: _____ **DOB:** _____

I would prefer to be contacted at:
□ Home # _____
□ Work # _____
□ Cell # _____
□ Email _____

I _____ give permission to the physicians and their staff at Greater Knoxville Dermatology, PLLC to leave messages regarding my healthcare in the following manner when I am not available:

Please mark ALL that apply

□ May ONLY leave information with me. (If you check here, no other choices should be marked.)

OR

□ May leave appointment reminders on my answering machine/voicemail.
□ May leave appointment reminders with my family.*

□ May leave lab/path results on my answering machine/voicemail.
□ May leave lab/path results with my family.*

□ May leave general questions/information on my answering machine/voicemail.
□ May leave general questions/information with my family.*

*If any are checked above, please list name of individual we may give information to:

Name: _____ Relationship: _____

Home # _____ Cell # _____

OR

□ I prefer that ALL healthcare messages be given to the following person (family member, guardian, caretaker, or significant other):

Name: _____ Relationship: _____

Home # _____ Cell # _____

Patient (or Legal Guardian) Signature: _____ Date:_____

Completed by: □ Patient □ Parent □ Legal Guardian

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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information for treatment, payment, or health care operations but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time. Upon official notification to the office, future disclosures will then cease.

I have received a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Legal Guardian Parent/Guardian Name

_____ _____

Witness Date