Registration - Phoebe Rich Dermatology

Phoebe Rich, MD Dr. Anna Hare Amy Simpson, PA-C

Patient Information

First, Middle, Last Name _____ Preferred Name and Pronouns _____ Date of Birth _____ Today's date _____

Address _____ City, State, Zip Code _____

Home Number _____ □ Best to reach Cell Number _____ □ Best to reach Work Number _____ □ Best to reach

E-mail address _____ ☐ I would like to be web-enabled and receive results, see chart notes and schedule appointments online.

Name of Family Physician _____ Phone Number _____

→ ☐ It is ok to share medical records between my medical providers when possible.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Sex: ☐ Male ☐ Female ☐ Transgender ☐ _____

Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Retired

Please complete the following for children under 18 years of age:

Parent/Guardian name _____ Phone number _____ Parent/Guardian name _____ Phone number _____

RACE: □ _____ □ Decline to answer ETHNICITY: □ _____ □ Decline to answer PREFERRED LANGUAGE: □ English □ Other _____

How were you referred to our office?

☐ By a Doctor ☐ By a Patient Please print the name of your source below.

Employment Information

Employer _____ Address _____ City, State, Zip _____

Person to Contact in Case of Emergency

Name _____ Phone Number _____ Relationship _____

Address (optional) _____ City, State, Zip (optional) _____

How Would You Prefer to be Contacted with Procedure Results?

☐ Telephone (Is it okay to leave a message? _____)

☐ Online through the Patient Portal (If you checked the web-enable box above you will be notified via the portal)

List persons we may leave messages with or discuss medical conditions with:

_____

Pharmacy Information

Preferred pharmacy: _____ Phone Number if Available: _____

Caretaker Information (If Applicable)

Name | Date of Birth | Relationship to Patient

Address | City, State, Zip Code

Phone Number | Cell Number | Occupation

Employer | Employer Phone Number

Insurance Information (if your insurance card was scanned in you can skip this section)

Name of Policy Holder | Date of Birth | Relationship to Patient

Insurance Company | Group Number | ID Number

Address | City, State, Zip Code

Consent to Treatment

Permission is given to Phoebe Rich Dermatology and staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition. We will be happy to discuss your concerns at any time. During your visit your health and safety are our main concern. We usually recommend a full skin examination for patients who are new to our office to search for and document benign and potentially malignant skin lesions. You can opt out of a full skin examination if you wish, but we recommend it at least once a year, especially if you have had a previous skin cancer. If a suspicious appearing or concerning skin lesion is discovered, a biopsy or surgical excision may be recommended. As with all medical and surgical procedures there are risks of scarring, infection at the surgical site, bleeding, allergic reaction to anesthesia, acute or chronic pain, and slow healing, especially on lower extremities and feet. We always do our best to minimize side effects and scarring, but scars and keloids can occur, and are more likely with removal of large skin cancers on the upper torso and face, even under the best surgical conditions. We want you to ask any and all questions that you may have regarding your skin treatment and surgical procedures, especially about the risks and alternative treatments that may be available, and we hope you will not hesitate to inquire. Our goal is to provide the very best care possible for your skin conditions, and to work together with you as a team and assure your skin health.

Financial Responsibility and Assignment of Benefits

☐ I **am** supplying Phoebe Rich Dermatology with insurance information. I authorize my insurance company to pay directly to Phoebe Rich Dermatology all benefits due for my medical care, and hereby consider this an assignment of benefits. I authorize Phoebe Rich Dermatology to provide all information my insurance company requests concerning my treatment. If my insurance company requires a referral from my primary care physician and I did not obtain a referral prior to my appointment, I am financially responsible for all services. It is understood that I am financially responsible for all services not covered or allowed by my insurance company, including out of office services such as pathology services and lab testing (also including deductibles and co-pays). Any money received in excess of my charges will be refunded when my bill is paid in full. I understand that if I do not show up for an appointment, or if I cancel with less than 24 hours notice, I will be charged a $50 fee.

-OR-

☐ I am **not** supplying Phoebe Rich Dermatology with insurance information. I understand that I am financially responsible for all services performed. I understand and will comply with the financial policy of Phoebe Rich Dermatology.

By printing my name below, I certify that I have read, agree, and consent to this document.

Patient or Other Legally Authorized Person | *Date*