MAJORS DERMATOLOGY REGISTRATION FORM

Patient Information:

Last Name: ______________________ First: ______________________ MI: __________

Address: ____

City/State/Zip Code: ____

Home Phone: (_____) ____________ Work Phone: (_____) ____________ Cell: (_____) ____________

Date of Birth: ______________________ Gender: ❒ Male ❒ Female

Marital Status: ______________________ Social Security No.: ______________________

E-Mail Address: ____

Employer's Name/Address: ____

____

Spouse's or Parent's Name: ____

Insured Name: ____

Insured Relationship: ______________________ Date of Birth: ______________________

Emergency Contact ***(Other than household member)*****:**

Name: ______________________ Phone: ______________________

Please name who is responsible for authorizing treatment and who will be responsible for the bill.

Name: ______________________ Relationship: ______________________

Mailing Address: ____

City/State/Zip Code: ____

Home Phone: (_____) ____________ Work Phone: (_____) ____________ Cell: (_____) ____________

All Medicare claims are filed by this office, as well as Medicare Supplemental and various PPO/PAR plans. If we do not file your insurance, you will be furnished with a receipt that you can use to file.

Check all Applicable: ❒ Medicare ❒ Private ❒ None

Please present all insurance cards to be copied so that they can be kept in your permanent file.

Referred by: ____

Financial Responsibility Agreement

I hereby understand that I am responsible for any and all charges and will pay for these charges at the time the services are rendered unless prior arrangements have been made.

Majors Dermatology retains the right to add a late fee to your balance owed if your account becomes delinquent and is turned over to a collection agency.

Method of Payment: ☐ Cash ☐ Check ☐ Visa/Mastercard

Signature Date

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Michael J. Majors, MD, PA to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though I had personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to Michael J. Majors, MD, PA all benefits if any. If payment is made to me by my insurance company I will promptly turn payment over to Michael J. Majors, MD, PA. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Michael J. Majors, MD, PA will be credited to my account, in accordance with this assignment.

Signature Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made to Michael J. Majors, MD, PA for any health care services provided to me. I authorize any and all health care professional(s) and/or facility(s) to release any of my medical information needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration and its agents. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "OTHER HEALTH INSURANCE" is indicated in the ITEM 9 box of the HCFA-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. If Medicare assignment applies, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature Date

PATIENT/GUARDIAN MUST SIGN THE APPROPRIATE SECTIONS BEFORE SEEING THE PHYSICIAN.

HISTORY AND INTAKE FORM

NAME: ______________________________ **DATE OF BIRTH:** ______________

Past Medical History (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD (Acid reflux)	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH (Benign Prostatic Hyperplasia)	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD (Emphysema)	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	

Other: ____

Past Surgical History (please circle all that apply)

Appendix Removed	Heart Valve Replacement	Lung Transplant
Basal Cell Cancer Surgery	Heart Transplant	Melanoma Surgery
Bladder Removed	Hysterectomy	Ovaries Removed: Endometriosis
Mastectomy (Right, Left, Both)	Joint Replacement, Shoulder (Right Left, Both)	Ovaries Removed: Cyst
Lumpectomy (Right, Left, Both)	Joint Replacement, Knee (Right, Left, Both)	Ovaries Removed: Ovarian Cancer
Breast Biopsy (Right, Left, Both)	Joint Replacement, Hip (Right, Left, Both)	Prostate Removed: Prostate Cancer
Breast Reduction	Kidney Biopsy	Prostate Biopsy
Breast Implants	Kidney Removed (Right, Left)	Spleen Removed
Colectomy: Colon Cancer Resection	Kidney Stone Removal	Squamous Cell Carcinoma Surgery
Colectomy: Diverticulitis	Kidney Transplant	Testicles Removed (Right, Left, Both)
Colectomy: IBD	Liver Transplant	Tonsillectomy
Gallbladder Removed		TURP
Coronary Artery Bypass		Skin Biopsy
Heart Stent		None

Other: ____

Skin Disease History (please circle all that apply)

Acne	Other
Actinic Keratoses	Hay Fever/ Allergies
Asthma	Hives
Basal Cell Skin Cancer	Melanoma
Blistering Sunburns	Poison Ivy
Chicken Pox	Precancerous Moles
Dry Skin	Psoriasis
Eczema	Squamous Cell Cancer
Flaking or Itchy Scalp	

Do you wear Sunscreen? If yes, what SPF? ___ Yes No

Do you tan in a tanning salon? Yes No

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

____

Any other family history?

____

Please enter all current medications and non-prescription medications.

Medications	Dosage	Frequency

Drug Allergies (please enter all allergies and type of reaction)

____

____

____

____

Social History (please circle one)

Cigarette Smoking:

Never smoked

Quit: (former smoker)

Smokes less than daily

Smokeless tobacco

Other:________________

Alcohol Use:

Yes

No

Ethnicity:

Hispanic/ Latino

Non-Hispanic Latino

Language:

English

Spanish

Race:

White

Black/ African American

Asian

American Indian or Native Alaskan

Native Hawaiian/ Pacific Islander

Other:______________________

Pharmacy:

Name: ____

City & Zip: ____

Do you have any of the following:

1. Latex allergy
2. HIV positive
3. Hepatitis
4. Allergy to lidocaine
5. Allergy to topical antibiotic ointments
6. Artificial heart valve
7. Artificial joints within past six months
8. Blood thinners
9. Defibrillator
10. **MRSA**
11. Pacemaker
12. Premedication prior to procedures
13. Rapid heart beat with epinephrine
14. Pregnancy or planning a pregnancy
15. Problems with bleeding
16. Problems with healing
17. Problems with scarring
18. Rash
19. Sun sensitivity
20. Immunosuppression
21. Hay fever

MAJORS DERMATOLOGY

Michael J. Majors, M.D.

Who is your Primary Care Doctor? ______________________________

Tobacco User

☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Unhealthy Alcohol Use: Screening & Brief Counseling

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? ____________________

Influenza Vaccine

Check the one that best fits:

☐ Received a flu vaccine this flu season

☐ Did not receive a flu vaccine this flu season because of medical reasons

☐ Did not receive a flu vaccine this flu season because I didn't want one

☐ Did not receive a flu vaccine this flu season

Pneumococcal Vaccine (for patients 65 and older ONLY)

☐ Received a pneumococcal vaccine (Pneumovax)

☐ Did not receive a pneumococcal vaccine (Pneumovax)

Other vaccines (for patients who are EXACTLY 13 years old). If you are not currently 13 years old, please skip this question. Check ALL that apply.

☐ Received one dose of meningococcal vaccine on or between my 11th and 13th birthday

☐ Received one tetanus, diphtheria and pertussis vaccine (TDAP) on or between my 10th and 13th birthday

☐ Received at least three HPV vaccines on or between my 9th and 13th birthday

Advanced Directives

Advance directives are designed to respect your autonomy and determine your wishes about future life-sustaining medical treatment if you are unable to indicate your wishes. Key intervention and treatment decisions are: resuscitation procedures such as Cardiopulmonary Resuscitation (CPR), and mechanical respiration (breathing tube).

Which statement(s) *best reflects* your wishes on advanced care recommendations?

☐ I want full cardiopulmonary resuscitation efforts to be made (Full Code).

☐ I do not wish to have a breathing tube, even it is necessary to save my life (Do Not Resuscitate).

☐ If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life (Do Not Resuscitate).

☐ I have a living will.

☐ I have a health care proxy whose name is ____________________, and contact phone number information is ____________________.

Patient Signature ______________________________

Michael J. Majors, M.D., P.A.
Majors Dermatology

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Majors Dermatology** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Majors Dermatology** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Majors Dermatology** Privacy Officer at 753 S. Washington St., Fredericksburg, Texas 78624.

With my consent, **Majors Dermatology** may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. This includes appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Majors Dermatology** may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, **Majors Dermatology** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Majors Dermatology** restrict how it uses or discloses my PHI to carry out TPO.

(OVER)

However, **Majors Dermatology**, is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Majors Dermatology's** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Majors Dermatology** may decline to provide treatment to me.

______________________________ ______________________________

Patient's Name Date

____

Signature of Patient or Legal Guardian

____

Print Name of Patient or Legal Guardian