INTEGRATED DERMATOLOGY OF EAST BOCA, LLC.

NEW PATIENT REGISTRATION

NAME: _____ **Date of Birth:** ____/____/____ **Social Security #:** _____
MM / DD / YYYY

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

GENDER: _____ **Home Phone #:**_____ **Cell#**_____ **Work Phone #:**_____

OCCUPATION:_____ **EMPLOYER:**_____

EMERGENCY CONTACT: _____ **RELATION:** _____ **Phone #** _____

NORTHERN ADDRESS: _____ **CITY:** _____ **STATE:** ____ **ZIP:**_____

EMAIL:_____ **RACE:**_____ **ETHNICITY:**_____

WHOM MAY WE THANK FOR YOUR REFERRAL: _____

ALL PATIENTS PLEASE COMPLETE AND SIGN BELOW

INSURANCE COMPANY_____ ID#_____

MEDICARE: _____ MEDICARE ID NUMBER: _____

I authorize any holder of medical information to release any information that is required by my insurance company. As the responsible party, I agree that all charges incurred by me or my dependents for services rendered by the Dr (except those paid directly by Medicare) are my financial responsibility. All court fees, attorneys fees or other fees necessary to collect this account are payable by me. In the event of litigation arising from any medical services received at any time I agree to binding arbitration and waive any other rights.

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS ONLY, PLEASE READ AND SIGN BELOW

We are participating physicians and will file your claim for you. Today you will be responsible for "your part" which is 20% (unless you have an approved supplemental policy) plus your unmet deductible for the current year. I request that payment of authorized MEDICARE benefits be made on my behalf to the Dr. for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I have not pledged or assigned my benefits to any Health Maintenance Organization (H.M.O.).

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS WITH SUPPLEMENTAL COVERAGE, PLEASE READ AND SIGN BELOW

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me.

SIGNATURE: _____ DATE: _____

SUPPLEMENTAL INSURANCE COMPANY NAME:_____

SUPPLEMENTAL POLICY NUMBER: _____

ALL PATIENTS PLEASE READ AND SIGN. I UNDERSTAND THAT ALL SPECIMENS (BIOPSIES AND CULTURES) WILL BE SENT TO AND BILLED BY AN INDEPENDENT LAB.

SIGNATURE: _____ DATE: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____	**ALLERGIES**	_____	**GLAUCOMA**
_____	**STOMACH ULCER**	_____	**HIGH BLOOD PRESSURE**
_____	**PACEMAKER**	_____	**TB/LUNG DISEASE**
_____	**PROSTATE PROBLEMS**	_____	**CANCER**
_____	**HEART DISEASE**	_____	**ECZEMA**
_____	**ASTHMA**	_____	**GLANDULAR/HORMONAL DISEASE**
_____	**ARTHRITIS**	_____	**BLEEDING DISORDER**
_____	**SEIZURES**	_____	**KIDNEY DISEASE**
_____	**COLITIS**		
_____	**LIVER DISEASE**	_____	**FAMILY HISTORY OF SKIN CANCER**
_____	**DIABETES**	_____	**# OF ALCOHOLIC DRINKS WEEKLY**
_____	**DO YOU SMOKE?**	_____	**I REQUEST A FULL SKIN EXAM**

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

ASPIRIN? _____

COUMADIN? _____

ANY BLOOD THINNERS? _____

ALL OTHER MEDICATIONS: _____

_____

IF YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS, PLEASE LIST THEM: _____

_____

ARE YOU PREGNANT? _____**IF YOU BECOME PREGNANT PLEASE ADVISE THIS OFFICE.**

HAVE YOU BEEN ADVISED TO TAKE ANTIBIOTICS BEFORE SURGICAL PROCEDURES?

_____

FAMILY DOCTOR: _____ **PHONE:** _____-_____ -_____