Advanced Dermatology of Southern Maryland
Patient Registration Form

Today's Date:		Primary Care Physician:	
Patient's Last Name: First:		Middle:	Date of Birth:
Street Address:	City:	State:	Zip Code:
Primary Phone:	Cell Phone:	Email:	Sex: Male Female
Ok to Leave Detailed Message? Yes No	Do you give permission for us to leave detailed message with family member? If yes, give name and number:		
Preferred Language: □ Chinese □ English □ French □ German □ Hebrew □ Italian □ Russian □ Spanish □ Other _____	Race: □ Asian □ American Indian/ Alaskan Native □ Black/African American □ Native Hawaiian/ Pacific Islander □ White	Ethnicity: □ Hispanic or Latino □ Not Hispanic/Latino □ Declined to Specify	Marital Status: □ Divorced □ Legally Separated □ Married □ Single □ Widowed □ Declined to Specify
IN CASE OF EMERGENCY			
Name of local friend or relative	Relationship to patient	Primary Phone	Alternate Phone

GENERAL OFFICE POLICIES

Notice of Privacy Practices – A Notice of Privacy Practices is available for your review. If you would like to have/read a copy, please ask the front desk for your copy.

Financial Policy – I hereby authorize Advanced Dermatology of Southern Maryland to apply for benefits on my behalf for the services I have received and release any pertinent medical information to my insurance carrier. I authorize payment of medical benefits directly to Advanced Dermatology of Southern Maryland. I understand that my insurance carrier may not cover all services provided and I may be responsible for any services that are not covered. I understand that I will be responsible for any fees ($25 currently) relating to my account being sent to an outside collection agency or attorney. This fee may change without notice. All cosmetic services are payable at the time of service.

Cancellation Policy/"No Show" Policy – Advanced Dermatology of Southern Maryland requires a 24 hour notice when cancelling any appointment. I understand that I may be liable for a charge of $25.00 ($100 for cosmetic appointments) if I fail to give 24 hours notice to cancel or I "no show" for an appointment.

Return Check Policy – Advanced Dermatology of Southern Maryland charges $35.00 for all returned checks.

I have read and understand the above policies.

Patient/Guardian Signature Date

Dermatology Medical History Form

Name_____ DOB ___/___/___ Reason for today's visit _____

Occupation_____ Type of work_____

Any contributing factors to symptoms

General Medical History: (Please check boxes that apply)

- ☐ **No contributing history**
- ☐ Antibiotics prior to dental procedure
- ☐ Hepatitis
- ☐ Anticoagulants
- ☐ High Blood Pressure
- ☐ Artificial Joints
- ☐ HIV/AIDS
- ☐ Asthma
- ☐ Hives
- ☐ Bleeding Disorder
- ☐ Kidney Stones
- ☐ Breast Cancer
- ☐ Pacemaker/Defibrillator
- ☐ Cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Eczema
- ☐ Tuberculosis
- ☐ Hay Fever/Seasonal Allergies
- ☐ X-Ray Therapy
- ☐ Heart Disease
- ☐ Heart Murmur

Past Surgeries/Hospitalizations (If None, please print none)

Skin History: (Please circle choices that apply)

No contributing history
Actinic Keratosis
Severe Sunburns
Basal Cell Carcinoma
Squamous Cell Carcinoma
Eczema
Tanning Bed Use
Malignant Melanoma
Urticaria
Other Suspicious Lesion
Psoriasis

Family History: (Please circle choices that apply)

No contributing history
Colon Cancer
High Blood Pressure
Lung Disease
Premature Coronary Heart Disease
Unknown-Adopted
Diabetes
High Cholesterol
Malignant Melanoma
Skin Cancer
Autoimmune Disorders
Glaucoma
Liver Disease
Obesity
Thyroid Disease

Allergies to medications and type of allergic reactions: (example: hives, difficulty breathing, swelling)

Current Medications:

Smoking Status: YES FORMER NEVER
Started: _____
Ended: _____

Pharmacy Information		
Name	Address	Phone Number

Signature of person filling out this Form:_____ Date:_____