Metrolina Dermatology and Skin Surgery Specialists

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Charlotte, NC 28210
(Phone): 980-299-3926
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330 Billingsley Road Suite 205
Charlotte, NC 28211
(Phone): 704-323-7243
(Fax): 980-217-7243

Dear Patient,

We thank you for choosing Metrolina Dermatology and Skin Surgery Specialists for your dermatologic needs. We look forward to seeing you at your upcoming appointment. The following information is intended to make the registration process easier and more efficient. In order to expedite the registration process, please complete the following forms. By completing these forms ahead of time, you will save a significant amount of time during your visit. You can also complete these online using our patient portal located on our website at www.metrolinadermatology.com. However, if you prefer to fill these forms out in the office, please arrive 30 minutes prior to your appointment time.

Please be prepared to provide the following at your appointment:

- Completed forms
- Current medical insurance care
- Photo identification
- Updated list of current medications
- A referral IF your insurance requires a referral

If have a specialist co-pay, we will collect that at time of service.

To allow for sufficient time for the registration process, please arrive 15 minutes prior to your first appointment, or 30 minutes if you choose to complete the forms in our office. We ask you to arrive prior to your appointment time to fill out these forms in order for our office to run smoothly and to respect every patient's time. If you arrive 5 minutes past your appointment, we will have the right to re-schedule you.

We appreciate your assistance with preparing for your appointment, and we look forward to providing you the highest quality dermatological care. If you have any questions or concerns regarding the registration process, or any questions about your appointment, please do not hesitate to contact our office.

Sincerely,

Metrolina Dermatology and Skin Surgery Specialists

Metrolina Dermatology and Skin Surgery Specialists

Patient Registration Form: PATIENT INFORMATION

Name:	Date of Birth:	Sex:
Street Address:	City/State	Zip Code:
Race:	Ethnic Group:	Preferred Language
Email address:		

Marital Status:

Single Married Divorced Widowed

Employer/Place of Employment: **Employer Phone number:**

Social Security Number:	Spouse Name (if applicable)	Caretaker Name (if applicable)

Pharmacy: *our office does electronic prescriptions – please list as much information as possible*

Name: _____ Location: _____ Phone: _____

Have you ever been seen by one of our physicians? ❑ Yes ❑ No (if yes, physician name)

Primary Care Provider: Full Name: _____ Location: _____

Phone: _____ Fax: _____ Did your Primary Care Provider refer you? ❑ Yes ❑ No

Did another physician refer you? ❑ Yes ❑ No **IF yes:** Name of referring Provider _____

Emergency Contact:
Name/Relationship: _____ Phone:_____

Medical Information Release (Privacy Policies are located at the reception desk)

Cell Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No
Home Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No
Work Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No

Circle your preferred contact method Cell Home Work Email

If you are not available may we leave a message with another person? If yes, please state below:

Name/Relationship _____

Name/Relationship _____

Signature _____ **Date**_____

Insurance Information

Insurance Name:_____
Primary Subscriber Name: _____ Relationship to patient: _____
Primary Subscriber Date of Birth: _____

Recent insurance policy changes and the popularity of high deducible plans have increased the number of bills and balances to patients. If you have not met your deductible for your plan year, please expect a bill from our office. Per our insurance contracts, we are unable to make adjustments to any outstanding balance.

Metrolina Dermatology
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Notice of Privacy Practices, Financial and Cancellation Policies

Date: _____

Full Name: _____ **DOB:** _____

Thank you for choosing Metrolina Dermatology and Skin Surgery Specialists. The following is our notice of privacy practices, financial policy and cancellation. Please review the policy, initial where indicated, sign and date at the bottom.

Notice of Privacy Practices: We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our staff to acknowledge that you have been provided a copy of our notice.

Paperwork: We request you routinely update your paperwork to ensure we have all the correct information on hand for billing purposes and to ensure excellent clinical care. This paperwork allows us to bill insurance in a timely manner and from preventing balances being unnecessarily transferred to you, the patient. We understand the frustration of completing paperwork and are constantly evaluating different methods to reduce the burden on you.

Missed appointments/Cancellations: We request a 24 hour advanced notification of cancellations and reschedules. We try to notify all patients of upcoming appointments using our computerized calling system and/or by reminder phone calls directly from the office. Unfortunately, we do experience errors with the system from time to time. **There is a $30 no-show fee for dermatology appointments and $150 fee for all surgical and cosmetic appointments if not cancelled before 24 hours**. Three (3) no-shows/late cancellations (less than 24 hours) will result in dismissal from our practice

Initial: _____

Insurance: Our practice is contracted with most commercial insurances and Medicare. We do not accept Medicaid. As a contracted provider, we agree to accept adjusted fees from your insurance company and bill in accordance with CPT and ICD 10 guidelines. We collect co-pays at the time of visit. Deductibles and other outstanding balances will be billed to you, after your claim has been processed by your insurance company. We are unable to determine prior to your visit what charges will be applied to your deductible. The patient is responsible for providing the most up to date insurance information prior to, or at the time of service. Patient is responsible for payment of services rendered in the event the incorrect insurance information was provided at the time of service.

Initial: _____

Cosmetic Procedures: For all cosmetic and laser procedures, **payment is expected in full at the time of procedure. We have a $150 no show fee (less than 24 hours) for all cosmetic appointments.**

Initial: _____

Lab Fee: Metrolina Dermatology and Skin Surgery Specialists use an outside laboratory for pathology services. The lab will bill you directly for these services.

Initial: _____

Patient is Responsible for Total Charge: Patients will be billed in full for any unpaid copayments or deductibles. Patient balances will be set by the adjusted rates as determined by our contract with your insurance company. In accordance with our contracts and Medicare guidelines we cannot make adjustments to these fees or the codes charges. If your insurance requires a referral and the necessary referral was not obtained prior to services rendered, the patient (or party responsible for billing as listed below) is responsible for total payment of services rendered. Any remaining balance must be paid before being seen for future appointments.

Initial: _____

My signature below indicates that I have read and agree to the above written Notice of privacy practice, financial policy, and cancellation policy of Metrolina Dermatology and Skin Surgery Specialists. I authorize release of any medical information necessary to process any claims filed

_____ _____

Signature of Patient (or Legal Representative) Date

Metrolina Dermatology and Skin Surgery Specialists

Metrolina Dermatology and Skin Surgery Specialists Intake Form

Account Number: _____

Name: _____ Date of Birth: _____ Today's Date: _____

Name of Referring Medical Professional/Primary Care Provider:_____

Drug Allergies: ☐Yes ☐No Latex Allergy: ☐Yes ☐No

If yes, list any drugs you are allergic to: _____

Part 1: <u>Past Medical History</u> (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH (benign prostatic hyperplasia)
Breast Cancer
Colon Cancer
COPD/Emphysema
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatments
Seizures
Stroke

NONE

Other: _____

Part 2: <u>Past Surgical History</u> (please circle all that apply)

NONE
Appendix (Appendectomy)
Bladder (Cystecomy)
Breast: Breast Biopsy
Breast Lumpectomy (Bilateral, Left, Right)
Breast Mastectomy (Bilateral, Left, Right)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy IBD
Colostomy
Gallblader Removal
Biological Heart Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
Heart: PTCA (percutaneous coronary angioplasty)
Joint Replacement, Hip (Bilateral, Left, Right)
Joint Replacement, Knee (Bilateral, Left, Right)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Nephrectomy
Liver Hepatectomy
Liver Transplant
Liver Shunt
Oophorectomy: Endometriosis
Oophorectomy: Ovarian Cancer
Oophorectomy: Ovarian Cyst
Ovaries: Tubal ligation
Pancreatectomy
Prostate Biopsy
Prostate Cancer
Prostate TURP (transurethral resection)
Rectum: Low anterior resection or ARP
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Biopsy
Skin: Squamous Cell Carcinoma
Splenectomy
Testicles: Orchiectomy
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer

Other: _____

Signature of responsible party/date _____

Name: _____ DOB: _____

Part 3: <u>Skin Disease History</u> (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other: _____

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

Do you tan in a tanning salon? ☐Yes ☐No

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

Part 4: <u>Medications</u> (please enter all current medications, supplements and OTC medications; include strength and dosage if known)

Medication Name	Dosage	Frequency	Route (oral, IV, IM)

Part 5: <u>Allergies</u> (please enter all allergies and type of reaction for each)

_____
_____
_____

Part 6: <u>Social History</u> (please circle all that apply

Cigarette/Tobacco Use: Never used
Former user
Current user
Packs per day: _____
How many years? _____
Date started/quit: _____

Alcohol Use: None
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Occupation: _____

Part 7: <u>Family History</u> (only first degree relatives: parents, sibling, children)

_____
_____
_____

Signature of responsible party/date _____

Name: _____ DOB: _____

Part 8: <u>Miscellaneous</u>

Have you ever tested positive for TB? ☐Yes ☐No

Have you ever received your flu vaccination? ☐Yes ☐No
If yes, what year? _____

Have you received your pneumonia vaccination? ☐Yes ☐No

Preferred Pharmacy:
Name: _____
Address: _____
Phone #: _____

Part 9: <u>Review of Systems:</u> Are you ***currently*** experiencing any of the following?

Problems with bleeding ☐Yes ☐No	Grey Discoloration of Skin ☐Yes ☐No	Sore Throat ☐Yes ☐No
Problem with healing ☐Yes ☐No	Hay Fever ☐Yes ☐No	Thyroid Problems ☐Yes ☐No
Problems with scarring (hypertrophic or keloid) ☐Yes ☐No	Headaches ☐Yes ☐No	Unintentional weight loss ☐Yes ☐No
Abdominal Pain ☐Yes ☐No	Immunosuppression ☐Yes ☐No	Vaginal Candidiasis ☐Yes ☐No
Anxiety ☐Yes ☐No	Joint Aches ☐Yes ☐No	Wheezing ☐Yes ☐No
Bloody Stool ☐Yes ☐No	(if yes, indicate year _____)	Red Eye ☐Yes ☐No
Bloody Urine ☐Yes ☐No	Menstrual Changes ☐Yes ☐No	Tearing ☐Yes ☐No
Blurry Vision ☐Yes ☐No	Muscle Weakness ☐Yes ☐No	Eye Pain ☐Yes ☐No
Chest Pain ☐Yes ☐No	Neck Stiffness ☐Yes ☐No	Uncontrolled blood pressure ☐Yes ☐No
Cough ☐Yes ☐No	Night Sweats ☐Yes ☐No	Elevated Blood Sugar ☐Yes ☐No
Depression ☐Yes ☐No	Rash/Hives ☐Yes ☐No	
Dizziness ☐Yes ☐No	Seizures ☐Yes ☐No	
Fever or Chills ☐Yes ☐No	Shortness of Breath ☐Yes ☐No	
	Sleeplessness ☐Yes ☐No	

Part 10: <u>Alerts:</u>

Allergy to adhesive ☐Yes ☐No	Ebola risk: fever > 100.4 ☐Yes ☐No
Allergy to lidocaine ☐Yes ☐No	West Africa: travel or contact ☐Yes ☐No
Allergy to topical antibiotic ointments ☐Yes ☐No	Ebola risk: contact w/ ebola patient without proper protective equipment within the last 21 days ☐Yes ☐No
Artificial heart valve ☐Yes ☐No	Ebola risk: headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain and/or hemorrhage ☐Yes ☐No
Artificial joints in last 2 yrs ☐Yes ☐No	
Blood thinners ☐Yes ☐No	Prostate Medications ☐Yes ☐No
Defibrillator ☐Yes ☐No	Transplant ☐Yes ☐No
MRSA ☐Yes ☐No	
Pacemaker ☐Yes ☐No	
Currently Pregnant or planning a pregnancy? ☐Yes ☐No	
Premedication prior to procedure ☐Yes ☐No	
Rapid heartbeat with epinephrine ☐Yes ☐No	

Signature of responsible party/date _____

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Medical Photography Consent Form

I consent for medical photographs to be made of me or the person for whom I am legal guardian **FOR MY MEDICAL RECORD** to document your dermatological care. By consenting to these medical photographs I understand that I will not receive payment from any party. By signing this form below I confirm that this consent form has been explained to me in terms that I understand. Refusal to consent to photographs will in no way affect the medical care I receive. If I have any questions or wish to withdraw my consent, I will contact the office.

Patient /Guardian Signature: _____ **Date:** _____

Patient Name (Print): _____ **Date:** _____

Witness: _____ **Date**_____

In addition, I confirm that I consent for medical photographs to be used for the following purposes: **Circle those that apply.**

1) for teaching and consultation with other physicians
2) for medical publications including textbooks and research studies
3) for promotional and marketing materials for Metrolina Dermatology, including electronic publications such as websites

I understand that identifying information, such as my name, will never be associated with these images. Refusal to consent to photographs will in no way affect the medical care I receive. If I have any questions or wish to withdraw my consent, I will contact the office. By consenting to these medical photographs I understand that I will not receive payment from any party. By signing this form below I confirm that this consent form has been explained to me in terms that I understand.

I understand that my photographs may be seen by physicians, scientists/researchers and members of the general public. In addition, while every effort will be made to obscure identifying features such as eyes or identifying tattoos, I understand that it is possible that someone may recognize me.

Patient /Guardian Signature: _____ **Date:** _____

Patient Name (Print): _____ **Date:** _____

Witness: _____ **Date**_____