PATIENT REGISTRATION FORM

PATIENT'S NAME:	DATE OF BIRTH:	TODAY'S DATE:
ADDRESS:	CITY/STATE:	ZIP CODE:
SEX: ☐MALE ☐FEMALE ☐ OTHER	EMAIL ADDRESS:	
IF UNDER THE AGE OF 18, NAME OF PARENT/GUARDIAN:		
PHONE: HOME ( )	CELL ( )	WORK ( )
PREFERRED METHOD OF CONTACT: ☐ HOME	☐ CELL	☐ WORK
RACE/ETHNICITY: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐BLACK OR AFRICAN AMERICAN ☐ HISPANIC ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐OTHER:___________ ☐DECLINE		
LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER:___________		
PREFERRED PHARMACY/CITY:		PHARMACY PHONE ( )
EMPLOYER:	ADDRESS:	
SPOUSE/PARTNER'S NAME:		SPOUSE/PARTNER'S DATE OF BIRTH:
EMERGENCY CONTACT (IF NOT SPOUSE):	PHONE ( )	RELATIONSHIP:
HOW DID YOU HEAR ABOUT OUR PRACTICE?		REFERRED BY:
METHOD OF PAYMENT: ☐ INSURANCE ☐ SELF-PAY (SKIP TO ASSIGNMENT OF INSURANCE BENEFITS)		
PERSON RESPONSIBLE FOR PAYMENT:		RELATIONSHIP:
BILLING ADDRESS:		PHONE ( )
PAYMENT REQUIRED AT TIME OF SERVICES/UNLESS PRIOR ARRANGEMENTS ARE MADE		
1) PRIMARY INSURANCE:		
POLICY HOLDER'S NAME:	RELATIONSHIP TO PATIENT:	POLICY HOLDER'S DATE OF BIRTH:
I.D.#	GROUP#	
2) SECONDARY INSURANCE:		
POLICY HOLDER'S NAME:	RELATIONSHIP TO PATIENT:	POLICY HOLDER'S DATE OF BIRTH:
I.D.#	GROUP#	
OTHER COVERAGE:		
$35 Charge for all returned checks *Cancellations with less than 24 hours' notice and no-show will result in a $50 appointment fee* *Cancellations with less than 24 hours' notice and no-show for Procedure Appointments will result in a $150 appointment fee*		

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to PREMIER DERMATOLOGY/DR. ADIL USMAN for services rendered by him in person or under his supervision. I understand that I am financially responsible for any non-covered (cosmetic) services or balance not covered by my insurance. I am responsible for obtaining a referral or pre-certification for the office visit or a procedure if my insurance company/HMO/POS requires one. I will be charged full payment if I DO NOT COMPLY. I certify that the information given by me in applying for payment is correct and I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original

PATIENT NAME (PLEASE PRINT): ______________________________ DATE: __________
PATIENT SIGNATURE: ______________________________
PARENT/GUARDIAN NAME (PLEASE PRINT): ______________________________ DATE: __________
PARENT/GUARDIAN SIGNATURE: ______________________________

Effective June 1, 2023:

Premier Dermatology will charge a fee to all patients who fail to cancel appointments at least 24 hours prior to their scheduled appointments.

If you do not cancel or reschedule your office appointment with at least 24 hours' notice, we will assess a $50 "no-show" service charge to your account. If you do not cancel or reschedule a surgical appointment with at least 24 hours' notice, we may assess a $150 "no-show" service charge to your account. These "no-show charges" are not reimbursable by your insurance company. You will be billed directly for them. Payment of these fees are required before you will be seen by our practice.

No-Show Policy

We schedule our appointments so that each patient receives the right amount of time and attention with our physicians and other clinicians. That's why it's very important for patients to arrive on time for your scheduled appointment.

As a courtesy, and to help patients remember their scheduled appointments, Premier Dermatology sends a reminder in advance of your appointment time. If your schedule changes and you cannot keep your appointment, please contact us as soon as you become aware and give us at least 24 hours' notice. We will attempt to reschedule you to accommodate those patients who are waiting for an appointment.

However, it is the responsibility of the patient to arrive for their appointment on the scheduled date and time. If you do not receive a reminder call or message, the above Policy will remain in effect.

How to Cancel or Reschedule Your Appointment:

To cancel or reschedule an appointment call Premier Dermatology at 703-726-0070. If you have any problems getting through, you can leave a detailed message with your name, date of birth and reason for cancellation/request to reschedule.

Patient Name: ____

Patient Signature: ____

Date: ____

44121 Leesburg Pike, Suite 210 Ashburn, VA 20147
480 West Jubal Early Dr, Suite 230 Winchester, VA 22601
201 North Maple Ave, Suite 201 Purcellville, VA 20132
Tel: (703) 726-0070   Fax: (703) 726-0935

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that effective January 1, 2011 any third party that will request for my medical records will be charged $25 for the first 10 pages, and $.50/per page after.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions.

Patient Name ____
Patient/Guardian Signature_______________________________________
Authorized Person(s)* ____
Relationship to Patient ____
Date____
*Any individuals listed here will be authorized to receive lab results, appointment reminders, diagnosis, treatments records etc.

Office Use Only:

I attempted to obtain the patient's signature acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: ____
Employee: _______________________________________
Reason: ____

Premier Dermatology
MEDICAL • SURGICAL • COSMETIC

MEDICAL HISTORY

Patient Name: ______________________________________ **Date of Birth:** _____________ **Today's Date:** __________
(Last, First, Middle Initial)

Patient Signature: ______________________________________

PAST MEDICAL HISTORY: *(Check all that apply. If none, please check none)*

- ○ Allergies *(Seasonal)*
- ○ Asthma
- ○ Bleeding Disorder *(or bleeding issue)*
- ○ Cancer: ________________
- ○ Coronary Artery Bypass
- ○ Depression
- ○ Diabetes
- ○ Fever Blister
- ○ Heart Valve Replacement
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ HIV/AIDS
- ○ Joint Replacement
- ○ Kidney Transplant
- ○ Liver Disease
- ○ Lumpectomy
- ○ Lupus/Rheumatoid Arthritis
- ○ Mastectomy
- ○ Organ Transplant
- ○ Seizures
- ○ Stroke
- ○ Thyroid Disease
- ○ NONE

DO YOU HAVE A HISTORY OF SKIN CANCER OR SKIN DISORDERES? YES_______ NO________
(Examples: acne, actinic keratosis, basal cell, melanoma, squamous cell)

If yes, please indicate condition or disorder: ____

FAMILY HISTORY OF SKIN CANCER INCLUDING MELANOMA? YES_______ NO________

If yes, whom and what kind of cancer? ____

MEDICATIONS: *(Enter all current medications including non-prescription and birth control; if none mark N/A)*

____

ALLERGIES: *(Please enter all allergies, including allergy to medications; if none mark N/A)*

____

SOCIAL HISTORY:

Do you smoke? YES_______ NO________ If yes, how much? ______________________________

Do you drink alcohol? YES_______ NO________ If yes, how much? ______________________________

REVIEW OF SYSTEMS:

- ○ Problems with bleeding
- ○ Problems with healing
- ○ Problems with scarring/keloids
- ○ Fever or Chills
- ○ Night Sweats
- ○ Unintentional Weight Loss
- ○ Joint Pain

ALERTS: *(Check all that apply. If none, please check none)*

- ○ Allergy to Adhesive
- ○ Allergy to Lidocaine
- ○ Allergy to Topical Antibiotics
- ○ Artificial Heart Valve
- ○ Artificial Joint Replacement
  If yes, indicate where__________
- ○ Blood Thinners
- ○ Defibrillator
- ○ MRSA
  Pacemaker
- ○ Require antibiotics prior to a surgical procedure
- ○ Rapid heartbeat with Epinephrine
- ○ Are you pregnant or currently trying to get pregnant?
- ○ Breastfeeding
- ○ NONE

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