JANE T. CHEW, M.D.
Columbia Dermatology Center

Please email these forms to: results@columbiadermatology.com

- Please include a copy of insurance card (back and front) and photo ID
- Use "last name_first name_DOB" in your subject line of your email

410.772.0707 • PATUXENT CENTRE • 10910 LITTLE PATUXENT PKWY., SUITE 205 • COLUMBIA, MARYLAND 21044

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PATIENT REGISTRATION FORM

NAME________________________________ DATE OF BIRTH______________
First Middle Last

SEX: **M** **F**

MARITAL STATUS____________

ADDRESS____
Street City State Zip

HOME #:________________ WORK #:________________ CELL #________________

PREFERED CONTACT #: **HOME/WORK/CELL** OCCUPATION:________________

EMAIL:________________ EMPLOYER:________________

EMERGENCY CONTACT:________________ PRIMARY CARE PHYSICIAN:________________

PRESENT YOU INSURANCE CARD (S) FOR PHOTOCOPY AND COMPLETE BELOW

If no card is available, payment in full is expected.

PRIMARY INSURANCE COMPANY	**SECONDARY INSURANCE COMPANY**
Company Name________________	Company Name________________
Policyholder: Yourself **Y N**	Policyholder: Yourself **Y N**
If No, complete below:	If No, complete below
Policyholder Name:________________	Policyholder Name:________________
SEX: **M** **F** Birthdate:____________	SEX: **M** **F** Birthdate:____________
RELATIONSHIP_________	RELATIONSHIP_________

Do we have your permission to:

Leave a message on your answering machine at home or mobile phone?	____yes	____no
Leave a message at your place of employment?	____yes	____no
Discuss your medical condition with any member of your household?	____yes	____no

Pharmacy of choice: ________________________________

PAYMENT AND INSURANCE AGREEMENT

I attest the above information is correct and will be used for billing purposes. I authorize release of medical information to my insurance company (s), primary care or referring physician and pharmacies. Further, your signature authorizes the Doctor to release medical information necessary to process your insurance claims (if any). If my insurance company does not pay, I understand that I am responsible for my bill. I understand that I am responsible for my bill. **Charges, deductibles, copays, and/or coinsurances are due at the time of service. A charge of $25.00 may be assessed for a missed appointment. Also, if we are forced to turn your account over to our collection agency, you will be responsible for all collection fees incurred. I understand that I am responsible for obtaining a referral from my primary care doctor if required by my insurance. If I fail to obtain the referral, I will be responsible for my bill.** I authorize Columbia Dermatology Center to act as my agent in helping me obtain payment from my insurance company (s). I authorized payment directly to Columbia Dermatology Center. A copy of this can be used in place of the original.

You will be given the opportunity to review our Notice of Privacy Practices. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996. Please initial to confirm this opportunity.

Signature________________________________ Date________________

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DERMATOLOGY MEDICAL HISTORY

To help us provide you with optimal health care, please take time to accurately complete this form and provide us with this vital information.

Name (print):____ **Date:**___________________________

Reason for today's visit:____

Past Medical History

Please check if you have ever had any of the following:

Anxiety _____ Arthritis _____ Asthma _____ Atrial Fibrillation (Irregular Heartbeat) _____

Bone Marrow Transplantation _____ BPH _____ Breast Cancer _____ Colon Cancer _____

COPD _____ Coronary Artery Disease _____ Depression _____ Diabetes _____

End Stage Renal Disease _____ GERD _____ Hearing Loss _____ Hepatitis ____

Hypertension _____ HIV / AIDS _____ Hypercholesterolemia _____ Hyperthyroidism _____

Hypothyroidism _____ Leukemia _____ Lung Cancer _____ Lymphoma _____

Prostate Cancer _____ Radiation Treatment _____ Seizures _____ Stroke _____

List any other diseases or conditions, or provide details about the above items:___________________________________

____

List any surgical procedures you have had in the past 6 months:____

____

Skin History

Have you ever had skin cancer?____

Do you have a history of any specific skin diseases? ____

Has anyone in your family had skin cancer?____

Do you have problem with healing? ____

Do you develop keloids or scars after surgery?____

Do you bleed easily? ____

Have you ever had a bad reaction to any dental anesthesia (Novocain)? _____________________________________

Please list all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins, and herbs):____

____

Please list any allergies, including allergies to medications:____

Social History

Have you ever smoked? ____ If yes, are you a: (current smoker / former smoker; quit: __________)

Have you ever used IV drugs? ____ Do you drink alcohol?____ If yes, ____drinks per day.

The above is true and correct to the best of my belief: ___________________________ _____________

Signature Date

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Financial Policy

We are pleased that you have selected our office to provide your Dermatologic care. As part of that care, we have developed this statement of our financial policy. Please carefully read the following, initial where indicated, and sign below.

Health Insurance Participation

______ Initials

Columbia Dermatology participates in many, but not all health insurance plans. If we do participate with your health insurance plan, you must present a valid insurance identification card at check-in. Without a valid insurance card, or if we do not participate in your health insurance plan, you may reschedule your appointment or payment for your visit will be due today.

Co-payments

______ Initials

Some insurance plans require payment of a Co-pay. Co-payments are due at check-in. Payments can be made by check, cash, MasterCard or VISA. Without a co-payment, you may be rescheduled.

Referrals

______ Initials

Some insurance plans require a written referral from a primary care provider. Referrals must be presented at check-in. Having a valid referral is a patient's responsibility. It is your responsibility to know how many visits are allowed on your referral and the expiration date of your referral. Without a valid referral, your appointment may be rescheduled or payment for your visit will be due today.

Financial Responsibility

______ Initials

Patients are responsible for all co-payments, deductibles, and charges not covered by health insurance.

Account Balances

______ Initials

All outstanding balances must be paid at time of check-in, or you must reschedule your appointment. We offer the convenience of having your credit card information securely filed to automatically cover any outstanding balances on your account. Failure to pay outstanding balances may result in the practice forwarding your account to a Collection Agency or Collection Attorney of our choice and may result in additional fees, including an administrative fee of 30%.

Rescheduling/Canceling Appointments

______ Initials

Please help us serve you by keeping your scheduled appointments. Should you need to change your appointment, contact our office at least 24 hours prior to your originally scheduled visit. Following two consecutively missed appointments, a $25 missed appointment fee will be charged. After three consecutively missed appointments, the scheduling of future appointments would be at the discretion of your physician.

If you are more than twenty (20) minutes late for your appointment, you will be asked to reschedule your appointment

I have read and understand the office policies explained above.

______________________________ ______________

Patient/ Responsible Party Signature Date