BETTER HEALTH AND SKIN CARE M.D. INC.

®

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: ____-____-_____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient's Employer: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____ Relationship to Patient: _____

Inova Medical Group reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee schedule: New Patient $50.00; Established Patient: $35.00

Patient / Parent or Guardian Signature: _____ Date: _____

BETTER HEALTH AND SKIN CARE M.D. INC.

Personal Information

Date:_____

Patient Name: _____ Birth Date: _____/_____/_____ Age: ____

Occupation _____ Marital Status: _____ Name of Partner/Spouse: _____

Race: ☐ Asian ☐ Black or African American ☐ Native American ☐ White / Caucasian ☐ Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____

Number of children: _____ Children's Names/Ages: _____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:_____

_____

_____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy**: _____

Date of Last Complete Physical Exam: _____ Date of Last Blood Work: _____

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

For Females: Date of Last Menstrual Period: _____ Date of Last Pap Smear: _____

History of Abnormal Pap (list date/s)? _____ Date of Last: Mammogram: _____ DEXA: _____

Number of Pregnancies: _____ Miscarriages: _____ Terminations: _____ Living Children: _____

Method/s of Contraception: _____

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If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD	Type 1 or 2 Diabetes	Respiratory Disease
Anemia	Fractures	Skin Disease
Allergies/Hay Fever	Gynecological Disease	Stomach/Colon Disease
Asthma	High Blood Pressure	Stroke
Arthritis	High Cholesterol	Seizure Disorder
Anxiety/Depression	Heart Attack	Thyroid Disorder
Alcoholism	Kidney Disease	Sexually Transmitted Disease
Blood Clots	Liver Disease	Other:
Cancer, Type/s _____	Neurological Disease	_____
	Osteopenia/Osteoporosis _____	

Please list any **SURGERIES** you have had and include the month/year:

_____

_____

_____

_____

Social Information

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____ Do you chew tobacco? _____ Have you thought about quitting? _____ Have you quit before? ____ How long?____

Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? _____ When? _____

Do you **exercise**? _____ What activities do you do, and how often in 1 week?_____

_____

Are you on any special **diet**? _____ If so, what? _____

Do you consume any **caffeinated** products? _____ If so, what and how much per day? _____

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities? _____

Do you have a living will? _____ If yes, please provide us a copy.

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s)to Better Health and Skin Care MD, Inc.for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Better Health and Skin Care MD, Inc. for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider this medical service rendered during my visit, a covered service or has not authorized this service, they will not pay for this service t. I agree to be fully responsible for payment to Better Health and Skin Care MD, Inc. for this service, if determined by my Insurance Plan(s) to be a non-covered service.

3. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

4. **For Medicare Recipients Only** - I certify the information given by me in applying for payment is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Better health and Skin Care MD Inc. for any services furnished to me by Better Health and Skin Care MD Inc. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

5. **Residents, Interns or Medical Students-** I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of Better Health and Skin Care MD Inc, progarm .

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Betther Health and Skin Care MD Inc . *I understand and agree this document will remain in effect for all future physician office visits to Better Health and SKin Care MD Inc, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____

I certify that I have been made aware of Better Health and SKin Care MD Inc.'s **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Better Health and Skin Care MD Inc. operations. The Notice also describes my rights and Betterh Health and Skin Care MD Inc.'s duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas Better Health and Skin Care MD Inc.of**fice .**

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION