Family Dermatology, L.L.C
Paul A. Carbonaro, M.D., F.A.A.D.

900 Route 168, Suite F5
Turnersville, NJ, 08012
856 - 232 - 7500

PATIENT REGISTRATION FORM

Please bring your insurance card and photo ID to your appointment

Patient Name: ____ Date of birth: ___________________

Sex: M / F Marital Status: ___________________________ Social Security Number: _______-_______-_______

Address: ____ City: _______________ State: ______ Zip: _________

Home phone: ____ Cell: ______________________________________

Occupation: ______________________________________ Work Number: _________________________________

Employer Address: ____

Emergency contact (name & number) : ______________________________________ Relation: _______________

Referring Doctor: ____

Health Insurance Information

Primary Insurance___________________________ Policy # ____________________________ Group #__________

Secondary Insurance_________________________ Policy # ____________________________ Group #__________

Responsible Party and Cardholders Information

Name______________________________ D.OB: _________________ Relationship: _______________________

Address: ____ City: _____________ State: _____ Zip:_________

Home Phone: ____________________________________ Cell: ____

Drivers License #: ____ Social Security Number: ______-_____-______

Employer (Address/Phone#): ____

Pharmacy Information Please give us the following information to facilitate getting your prescriptions.

Pharmacy: ____ Phone #______________________________

Address: ____

Office Policies:

Payment is due at the time of service. All co-payments are to be paid at the time of service regardless of insurance coverage. All cosmetic procedures are to be paid prior to the time of service. If you are unable to attend a scheduled appointment, you are required to call and cancel the appointment at least 24 hours in advance. Failure to cancel an appointment within 24 hours will result in the assessment of **a $30 late fee.**

Assignment & Release

I certify that I, and/or my dependents have insurance coverage and assign directly to Dr. Carbonaro all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services

____ _______________
(Please Print Name of Patient, Parent/Guardian) (Date)

____ _______________
(Signature of Patient, Parent/Guardian) (Date)

FAMILY DERMATOLOGY PATIENT HISTORY FORM

Patient Name: ______________________________ D.O.B: ____/____/____Today's Date: __________

Please read and check the box for the appropriate response regarding your medical history.

General	**YES / NO**
History of Cancer	☐☐
Painful Urination	☐☐
Recent Fever or Chills	☐☐
Appetite change	☐☐

Female Patients Only	
Currently Pregnant	☐☐
Currently Breastfeeding	☐☐

Male Patients Only	
Sores on penis	☐☐

Eyes	
Vision Problems	☐☐
Eye Pain/Discomfort	☐☐

Gastrointestinal:	
Abdominal Pain	☐☐
Nausea/Vomiting	☐☐
Indigestion/Heartburn	☐☐

Neurological	
Frequent Headache	☐☐
Numb/Tingling Hand/Feet	☐☐
Anxiety Disorder	☐☐
Mood Swings	☐☐
Depression	☐☐

Endocrine	☐☐
Diabetes	☐☐
Always Tired/ Sluggish	☐☐

Ear/Nose/Throat	**YES / NO**
Ear Infection	☐☐
Sore Throat	☐☐
Sinus Problems	☐☐

Skin	
Cold sores, fever blisters	☐☐
Eczema	☐☐
Psoriasis	☐☐
Severe Acne	☐☐

Musculoskeletal	
Joint Replacement	☐☐
Joint Pain/Arthritis	☐☐

Cardiovascular	
Pacemaker	☐☐
Chest Pain	☐☐
Varicose Veins	☐☐
High Blood Pressure	☐☐
Heart Valve Problem	☐☐

Respiratory/Allergic	
Wheezing/ Asthma	☐☐
Frequent Cough	☐☐
Hay Fever	☐☐

Hematological/Lymphatic	
Bleeding Problems	☐☐
Blood Clot or Stroke	☐☐
HIV positive test	☐☐
Healing Problems	☐☐
Bleed Easily	☐☐
Bruise Easily	☐☐

Drug Allergies	**YES / NO**
Anesthetics	☐☐
Codeine	☐☐
Penicillin	☐☐
Tetracycline	☐☐
Novocain	☐☐
Aspirin	☐☐
Iodine	☐☐
Erythromycin	☐☐
Sulfa	☐☐
Lidocaine	☐☐

Other:_____________________

Non-Drug Allergies	
Latex	☐☐
Tape	☐☐
Food	☐☐

Other: ____________________

Current Medications	
Vitamins	☐☐
Herbals	☐☐
Supplements	☐☐
Over the counter	☐☐
Prescriptions	☐☐

- If yes, please list

  ____

  ____

  ____

  ____

List any other diseases or conditions: ____

List surgical procedures you have had in the past: _____________________________________

Have you ever been examined by Dermatologist before? ☐Yes ☐No

-If **yes**, for what condition? ____

Have you or a family member ever had the following?

Melanoma	☐Self	☐Family
Other Skin Cancer	☐Self	☐Family
Psoriasis	☐Self	☐Family
Eczema/Dermatitis	☐Self	☐Family
Moderate or Severe Acne	☐Self	☐Family

-Do you smoke?: __Y / N__

If Yes, how often: ______________________________

-Do you use recreational drugs?: __Y / N__

If Yes, how often: ______________________________

-Do you drink?: __Y / N__

If Yes, how often: ______________________________

-List your hobbies: ______________________________

____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form

Signature: ____Date: ______________________________

Family Dermatology
HIPAA Notice Of Privacy Practices

We are required by law to maintain the privacy of protected health information and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA compliance officer in person or by phone at our main phone number 856-232-7500.

By signing this form you are also allowing our office to:

(1) Confirm appointments at your home by phone or answering machine
(2) Disclose medical information requested by other treating physicians
(3) Leave messages or discuss medical information with your pharmacist
(4) Disclose medical information to your lab/insurance company
(5) Request medical records when necessary from physicians or health care facilities.
(6) Leave messages regarding medical information, such as test results, on answering machines

I hereby give permission to disclose health information such as test results about me to the following people. I have the right to withdraw or revise my permission at any time, in writing:

____

Name Relation Phone Number

______My initials and signature below are indication of my general consent and authorization, for this and subsequent visits, for evaluation and treatment at Family Dermatology including the taking of appropriate history, physical exam, and other tests or procedures necessary for my medical care.

______My initials and signature below also authorize Family Dermatology, or its agent, to release to my insurance company(ies), any or all medical records in its possession, necessary for claims review and adjudication, for this and subsequent visits. I also authorize payment of medical benefits from my insurance company(ies) directly to Family Dermatology. I permit a copy of this authorization to be used in place of the original.

______My initials and signature below indicate my understanding that payment by my insurance may not represent full payment for services rendered, and that I will be responsible for the balance due as allowed by my insurance carrier.

Medicare patients only, please initial and sign below

______My initials and signature below authorize Family Dermatology, or its agent, to release to the Centers for Medicare and Medicaid Services, Social Security Administration, and Medicare (or its intermediaries or carriers) any and all medical information needed for this or subsequent Medicare claims. I request that payment of medical insurance benefits be made directly to Family Dermatology. I permit a copy of this authorization to be used in place of the original.

______My initials and signature below authorize Family Dermatology, or its agent, to release to my Medigap ("secondary insurance") carrier any and all medical information needed for this or subsequent claims. I also request that payment of medical insurance benefits from my Medigap ("secondary insurance") be made directly to Family Dermatology. I permit a copy of this authorization to be used in place of the original.

Your signature below is an acknowledgement that you have received this notice or our privacy practices.

________________________________ ________________________________

Print Name Date:

________________________________ ________________________________

Signature Date:

08/08