Sica Family Dermatology, PLLC

NEW PATIENT REGISTRATION

Today's Date:

Please complete the following information for our records at Sica Family Dermatology.

Last Name: First Name: Middle Initial:

Street Address:

City: State: Zip:

Age: Date of Birth: SSN:

Gender: M F Marital Status: Single Married Widowed Divorced

Home Phone:

Cell Phone: Work Phone:

Primary Care Physician: Phone:

Referring Physician: Phone:

Employer:

Employer Address: Employer Phone:

E-mail:

INSURANCE INFORMATION

Primary Insurance Name: Policy Holder's Name

ID: Policy Holder'sBirthdate

Group Number:

Relationship of patient to the Insured?

SECONDARY INSURANCE (if any):

PARENT OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT):

Name of Person Completing Form: Last Name: First Name:

Relationship to Patient: Mother Father Guardian Other: Phone

Address (*if different from patient*):

EMERGENCY CONTACT:

Last Name: First Name: Middle Initial:

Relationship to Patient: Phone Number:

Address:

City: State: Zip:

How did you hear about our clinic?

Reason for today's visit?

I CERTIFY THAT ALL OF THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND I AGREE TO NOTIFY SICA FAMILY DERMATOLOGY IN A TIMELY MANNER OF ANY CHANGES.

Signed: Date:

Sica Family Dermatology, PLLC

MEDICAL HISTORY FORM

Patient's Name: **Date of Birth:**

Last **First** **M.I.**

Are you allergic to any medications?: Yes No (if yes, list below:)

1. 2. 3. 4.

Have you ever had dental anesthesia (Novocain)? Yes No Any Bad Reaction? Yes No

List all medications you are currently taking (incl. prescriptions, over-the-counter meds, vitamins, and herbals):

1. 2. 3. 4.

5. 6. 7. 8.

LUNGS	**YES**	**NO**
Bronchitis	___	___
Emphysema	___	___
Asthma	___	___
Chronic Cough	___	___
Morning Cough	___	___
Shortness of Breath	___	___
Wheezing	___	___
CARDIOVASCULAR	**YES**	**NO**
High Blood Pressure	___	___
Chest Pain	___	___
Heart Attack	___	___
Heart Murmur	___	___
Irregular Heartbeat	___	___
Phlebitis	___	___
Inflammation of vein	___	___
Blood clots	___	___
Pacemaker	___	___

OTHER SYSTEMIC	**YES**	**NO**
Diabetes	___	___
Excessive thirst/hunger	___	___
Thyroid Disorder	___	___
Kidney	___	___
Bladder	___	___
Frequency/burning	___	___
Gastrointestinal	___	___
Stomach absorptive disorder	___	___
Nausea, vomiting, diarrhea	___	___
when taking antibiotics	___	___
Yeast infection	___	___
when taking antibiotics	___	___
Arthritis/Joint Deformity	___	___
Arthralgia	___	___
Limited Motion	___	___
Artificial joint	___	___
Convulsions/Epilepsy/Seizures	___	___
Fainting	___	___

FEMALES	**YES**	**NO**
Pregnant	___	___
Nursing	___	___
Tubal Ligation	___	___
Hysterectomy	___	___
Uterine Ablation	___	___
Birth Control	___	___
method		

OTHER	**YES**	**NO**
Have you had Surgeries in the past 6 months?	___	___

Is there anything else you feel we should know about you?

___

___

___

___

SOCIAL HISTORY

Smoke? YES NO If yes, how often? ___

Alcohol? YES NO If yes, how often? ___

Recreation Drug Use? ___

SKIN

Have you ever had skin cancer? YES NO If yes, when? ___

Has anyone in your family had skin cancer? YES NO

Do you have a history of any specific skin diseases? YES NO If yes, which? ___

Do you have problems with healing? YES NO

Do you develop keloids (scars) after surgery? YES NO

Do you bleed easily? YES NO

Do you develop skin rashes in reaction to: Meds/Food/Environment? ___

Patient or Responsible Party (signature): **Date**:

Sica Family Dermatology, PLLC

PATIENT CONSENT FORM

Patient's Name: _____ **Date of Birth:** _____

Last **First** **M.I.**

Please initial each item below. All items must be initialed before you can be seen.

_____ I consent to necessary treatment, including drug, medicines, performance of operations and conduct of studies that may be conducted by Dr. Sica and/or his staff.

_____ I understand that I may be charged **$50 for a missed appointment** or cancellation within 24 hours of appointment.

_____ I understand that **if I am uninsured or have an insurance that is not accepted** at the practice, that I will be responsible for payment IN FULL at the time of service.

_____ I understand that **insurance copays, deductibles, co-insurance and charges not filed with insurance are due at the time of service**. Failure to make payment when requested is a basis for legal action, and the undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State of Washington and any other state.

_____ I understand that **I will be responsible for ANY charges that are not paid by my insurance company**. Not all services are covered, and I understand that it is MY RESPONSIBILITY to know the limits of my coverage and to pay any fees that my insurance company denies. (As a service to you, our staff will bill your insurance carrier, but if you do not pay your balance in a timely fashion, we will ask that you pay in full at your visits and file your own claims.)

_____ I understand that **most procedures may fall under major medical, therefore I will be responsible for paying the deductible amount at the time of service**. Procedures include treatment of skin lesions (including warts, molluscum, moles, tags, pre-cancers, skin cancers) by ANY method (including freezing, biopsy and in-office application of medication).

_____I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

_____I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or any related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

_____ I am aware that the practice has a **Notice of Privacy Practices** that contains a section on Patient Rights. I have been given the opportunity to review this Notice.

Patient or Responsible Party (signature): _____ **Date**: _____

To better serve you, we send appointment reminders and other non-medical information relating to the practice via email and text messaging.

Please initial here if you do NOT want emails/texts for these purposes. _____no texts _____no emails

For test results and general medical issues, we may need to call, text, or email you. No sensitive or serious matters will be communicated to you via text or email. If we call, we need your permission to leave a message on voicemail or with a person.

Please initial here if you do NOT want test results and general medical issues to be communicated to you via…

_____no texts _____no email _____not on voicemail _____not with family members