THE MENKES CLINIC
Medical, Pediatric, Surgical and Cosmetic Dermatology

PATIENT REGISTRATION INFORMATION

PLEASE PRINT CLEARLY (PLEASE COMPLETE ENTIRE FORM)

Date: _____/_____/_____

Name: _____
LAST FIRST M.I. NICKNAME

Address: _____ Home Phone: (_____)_____
STREET APT #

City: _____ State:_____ Zip: _____ Work/Cell Phone: (_____) _____

Email: _____ Sex: M F Birthdate: _____/_____/_____ Age: _____
CIRCLE ONE

Emergency Contact: _____ Phone #: (_____)_____

HIPPA PATIENT PRIVACY	I authorize The Menkes Clinic to discuss my appointment, financial and medical data with: Name _____ Relationship _____ I request Special Privacy Protection to restrict health information disclosure (separate form) Y ___ N___

Primary Care Physician: _____ Office Phone: (_____)_____

How were you referred to our office? _____

IF PATIENT IS A MINOR Parent's Name _____

Cell Phone Father (_____)_____ CellPhone Mother (_____)_____

POLICYHOLDER (Member) INSURANCE INFORMATION

PLEASE COMPLETE ALL INSURANCE INFORMATION AND PRESENT
YOUR INSURANCE CARD AND PHOTO ID TO THE RECEPTIONIST.

Primary Insurance _____

Subscriber Name: _____
NAME OF THE POLICY HOLDER

Relationship to Subscriber: _____

Subscriber's Birthdate: _____/_____/_____

Subscriber's Social Security No.: _____
COMPLETE IF MEDICARE IS PRIMARY

Secondary Insurance _____
COMPLETE ONLY IF APPLICABLE

Subscriber Name: _____
NAME OF THE POLICY HOLDER

Relationship to Subscriber: _____

Subscriber's Birthdate: _____/_____/_____

Subscriber's Social Security No.: _____
COMPLETE IF MEDICARE IS PRIMARY

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FINANCIAL POLICY

PLEASE READ ENTIRE FORM AND SIGN AT THE BOTTOM

The Menkes Clinic and Surgery Center is committed to providing you with the best possible medical care. If you covered by medical insurance, we wish to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our financial policy.

We are contracted with many insurance companies and if you have a question regarding whether or not we are contracted with your plan, please contact your insurance company as they can best answer your questions. **In order to be able to file your insurance claims, we must have a copy of your insurance card. When there is a change in your insurance plan or coverage, please notify us as soon as possible.** Without this information, we will be unable to submit your claim to your insurance for payment.

1. Your insurance coverage is a contract between you and /or your employer, and the insurance company. We are not a party to that contract.
2. As a specialist, some insurance companies require that prior to any visit; you must obtain an authorization or referral from your primary care physician (PCP). If this is not done by the time of your appointment, you will be asked to either reschedule your appointment and contact your PCP, or pay for the services at the time you are seen. Any payments made at the time of service will be promptly refunded upon receipt of payment by the insurance company. Please note that most insurance companies will only cover the cost of the services listed on the authorization or referral. Any services which are not authorized or denied by your insurance company are your responsibility.
3. **Co-payments, if required by your plan, are due at the time of each visit.** Please come prepared to pay the copayment as determined by your insurance plan (most copayments are listed on your insurance card). Most insurance companies require that this amount be paid at the time of service in order to validate the contract.
4. No matter what type of plan you have, HMO, PPO, POS or Indemnity, it **is to your advantage, as well as your responsibility, to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts.** Contact your insurance company to find out what benefits are covered under your plan.
5. We request that as a courtesy to our other patients, that you **please notify us at least 24 hours in advance if you will be unable to keep your appointment.** We reserve the right to charge for any appointment which is not cancelled with proper notice.

We must emphasize that as medical care providers, our relationship is with you, not with your insurance company. Therefore, all costs for services provided remain the responsibility of the patient/guarantor from the date the service is rendered. We realize that temporary financial problems may affect timely payment in your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

All patient balances over 60 days old will be charged 1.5% interest.

I HAVE READ THE ABOVE FINANCIAL ARRANGEMENTS AND INSURANCE STATEMENT AND I REALIZE THAT PAYMENT IS MY OBLIGATION FOR COVERED AND NON-COVERED SERVICES REGARDLESS OF INSURANCE OR THIRD PARTY INVOLVEMENT. I AUTHORIZE THE PHYSICIAN TO FURNISH MY INSURANCE COMPANY WITH ANY INFORMATION REQUIRED AND MY INSURANCE BENEFIT PAYMENTS TO GO TO THE MENKES CLINIC AND SURGERY CENTER.

PATIENT SIGNATURE (guarantor, if patient is a minor) Date

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MEDICAL HISTORY

PLEASE PRINT CLEARLY
(PLEASE COMPLETE ENTIRE FORM AND SIGN AT BOTTOM)

Date: _____/_____/_____

Name: _____
LAST FIRST M.I. NICKNAME

Reason for visit: _____

Duration of symptoms: _____

Current treatment of skin condition: _____

Past treatments of skin condition: _____

What makes condition worse: _____

Family history of skin condition: _____

Are you allergic to any medications: ❑ Yes ❑ No If yes, please list:

1. _____ 2. _____

List all medication you are currently taking:

1. _____ 2. _____

3. _____ 4. _____

Do you have now, or have you ever had diseases or condition of: *(Choose all that apply)* ❑ None

❑ Nose/Throat
❑ Heart/Lungs
❑ Cancer
❑ Diabetes
❑ Asthma/Hayfever/Eczema
❑ Hepatitis
❑ HIV/AIDS
❑ Arthritis/Joint
❑ Autoimmune Diseases
❑ Epilepsy/Seizures _____
❑ Fainting

Do you have a history of any specific skin diseases: ❑ Yes ❑ No If yes, please list:

_____

Family history of above conditions *(Please list)*: _____

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

When are you exposed to sun, do you: ❑ Tan Only ❑ Tan and Burn ❑ Burn

Do you use sunblock: ❑ Yes ❑ No

Has anyone in your family had skin cancer: ❑ Yes ❑ No If yes, who: _____

Please answer the following questions:

A: Are you taking aspirin, blood thinners or anti-inflammatory medicines: ❑ Yes ❑ No

B. Do you smoke: ❑ Yes ❑ No If yes, how much: _____

C. (Women) Are you pregnant: ❑ Yes ❑ No If yes, what is your due date: _____/_____/_____

D. Do you have artificial joint(s): ❑ Yes ❑ No

_____ Reviewed By: _____
PATIENT SIGNATURE

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NOTICE OF PRIVACY PRACTICES

PLEASE PRINT CLEARLY
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the patient area, and that I have been offered a copy of any amended Notice of Privacy Practices at each appointment.

Print Name: _____ Date: _____/_____/_____

Signature: _____ Tele: (_____)_____

If not signed by the patient, please indicate:

Relationship: ❑ Parent or Guardian of Minor Patient

❑ Guardian or Conservator of an Incompetent Patient

❑ Beneficiary or Personal Representative of Deceased Patient

Name of Patient: _____

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PHONE MESSAGE / CONTACT AUTHORIZATION

PLEASE PRINT CLEARLY
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Print Name: _____ Date: _____/_____/_____

The doctors and staff of The Menkes Clinic have my permission to leave messages containing medical and/or financial information on my answering machine and/or email address provided below.

HOME: (_____)_____ ❑ YES ❑ NO

WORK/CELL: (_____)_____ ❑ YES ❑ NO

EMAIL: _____ ❑ YES ❑ NO

Note: If permission is not granted, only the date, time and location of your appointment, or a request to return our call will be left on your answering machine.

_____

NAME OF PATIENT (guarantor, if patient is a minor)

_____

SIGNATURE OF PATIENT (guarantor, if patient is a minor) Date