DENTON
DERMATOLOGY

PATIENT REGISTRATION

Sharif Currimbhoy MD PA
209 N Bonnie Brae St, Ste 205
Building 3
Denton, TX 76201

Patient Name_____ **Date**_____

Mailing Address_____ _____ _____ _____
STREET / PO BOX CITY STATE ZIP CODE

SS# _____-_____-_____ **Date of Birth**_____ **Email**_____

Home Phone_____**Cell Phone**_____**Age**_____**Gender** ☐ Male ☐ Female

Work Phone _____**Employer**_____

Occupation_____ **Student (Y/N)?** _____

Race ☐ White ☐ Asian ☐ Black or African American ☐ Other Race

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to specify

Preferred language ☐ English ☐ Spanish ☐ Other

For phone conversations is it best to contact: ☐ You ☐ Other (specify below)

Other Contact Name: _____**Relationship:** _____**Phone**_____

Do you have an advance directive or a surrogate decision maker? (Y/N)? _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Separated

Spouse's Name_____Spouse's Employer_____

Spouse's Work Phone _____Spouse's Occupation_____

In Case of Emergency Contact_____**Relationship**_____

Address_____**Phone**_____

Primary Care Physician_____**Referring Physician**_____

If Patient Is A Minor Or Student

Mother's Name_____Date of Birth_____SS#_____
Address_____
Home Phone_____Work Phone_____Employer_____
Employer's Address _____

Father's Name_____Date of Birth_____SS#_____
Address_____
Home Phone_____Work Phone_____Employer_____
Employer's Address _____

Person Responsible for Payment, If Not Above
Name_____Home Phone _____
Address_____

Parent, Guardian, Custodian, or General Agent authorizing and consenting to medical treatment:

✕ _____ ✕ _____
Signature **Printed Name**

INSURANCE INFORMATION

Primary Insurance _____ Phone #_____

Carrier's Address_____ _____ _____ _____
Street City State Zip Code

Insured (Policy Holder) _____Date of Birth_____

Relationship to Patient _____

Insured ID #_____

Secondary Insurance _____ Phone #_____

Carrier's Address_____ _____ _____ _____
Street City State Zip Code

Insured (Policy Holder) _____Date of Birth_____

Relationship to Patient _____

Insured ID #_____

Please present your Medicare and/or other Insurance card(s) to the receptionist for photo duplication. Payment for all professional services is expected at the time services are rendered, unless alternative arrangements have been made in advance. All deductibles, co-payments, and co-insurances must be paid at the time of the office visit. We accept cash, credit card, and checks. We do not accept Care Credit.

Our office files claims for Medicare assignment and any managed care plans with which we participate. If we do not file with your insurance carrier, you will be provided a detailed, itemized statement that you may submit to your carrier for reimbursement. We do not file on secondary insurances unless the primary insurance is Medicare.

I have completed this form fully, and I certify that I am the patient or the general agent or legal guardian of the patient duly authorized to furnish the information requested. I understand that I am fully responsible for payment of all services performed at the time they are rendered, with exceptions only as listed above. I hereby assign all medical and/or surgical benefits to include Medicare, private insurance, and any other health plans to: Denton Dermatology. I hereby authorize said assignee to release all information necessary to my insurance company, primary care physician, and/or other physician to process any claims/secure payment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Services provided for a minor are the responsibility of the accompanying adult, regardless of custodial status. I understand it is the policy of this office to report any delinquent balances to the credit bureau.

✕ _____ _____
Patient or Guardian Signature **Date**

PATIENT HEALTH INFORMATION

Patient Name_____ Date _____

Primary Pharmacy_____**Phone #**_____

How did you hear about us? _____

In your own words, please state the reason for your visit_____

_____

Duration of Condition_____Current treatment for this condition_____

Prior treatment for this condition_____

List **ALL** medications you are currently taking (including over the counter products, medications or supplements)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List **ALL** drug or environmental allergies

_____ _____ _____
_____ _____ _____
_____ _____ _____

PAST MEDICAL HISTORY

List other problems you have with your skin, hair, nails, or mucous membranes_____

_____

Please circle if you have any of the following currently or have had them in the past:

SKIN CANCER
MELANOMA
ACTINIC KERATOSES (Pre Cancers)
ASTHMA
HAY FEVER
KELOIDS/THICK SCARS
SKIN INFECTIONS
TANNING BED USE
HEPATITIS
HIV
VENEREAL DISEASE
URTICARIA (HIVES)
ECZEMA
LUPUS
RHEUMATIC DISEASES
HEART DISEASE
HYPERTENSION
MITRAL VALVE PROLAPSE
PACEMAKER
ARTIFICIAL HEART VALVE
ARTIFICIAL JOINTS/MATERIALS
BLEEDING TENDENCY
ANEMIA
FAINTING TENDENCIES
SEVERE HEADACHES
EPILEPSY/SEIZURES
KIDNEY DISEASE
LIVER DISEASE
IMMUNE SYSTEM DISORDERS
GENETIC DISEASES
THYROID DISEASE
CANCER
TYPE:_____
GASTROINTESTINAL DISEASE
ULCERS
DIABETES
EYE DISEASE
ORGAN TRANSPLANTATION
CHEMOTHERAPY
X-RAY TREATMENT
KNOWN RADIATION EXPOSURE
KNOWN ARSENIC EXPOSURE
PREVIOUS PUVA TREATMENTS

Comments:_____

Family Members with SKIN CANCER_____

Medical conditions in your family_____

Do you smoke? ☐ YES ☐ NO Drink alcohol? ☐ YES ☐ NO

When exposed to sunlight do you:

1) ☐ ALWAYS BURN
2) ☐ RARELY BURN, ALWAYS TAN
3) ☐ USUALLY BURN, RARELY TAN
4) ☐ OFTEN BURN, TAN SLOWLY
5) ☐ SOMETIMES BURN, TAN WELL
6) ☐ NEVER BURN

WOMEN ONLY

Are you or might you be pregnant? ☐ YES ☐ NO

Are you planning or attempting to become pregnant in the near future? ☐ YES ☐ NO

Are you on Birth Control Pills? ☐ YES ☐ NO Brand

FOR OFFICE USE ONLY

_____
_____
_____
_____
_____
_____
_____

Skin Type:_____

CONSENT FOR TREATMENT

General Consent: I hereby represent that I am over the age of 18 or that I am the parent/legal guardian of the patient being treated. Misrepresenting my age or my legal guardianship of the patient may violate federal and state health and privacy laws.

Further, by signing this form, I represent that any consent or form signed by myself or the minor has the consent of all interested parties involved in the care of the minor.

I hereby consent to medical, cosmetic and surgical treatment by Dr. Currimbhoy and any other services rendered during my visit with Denton Dermatology. Common services include physical exam, diagnostic testing such as lab draws and skin biopsies, wart and brown spot treatment, surgical excisions and cosmetic injections.

In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Dr. Currimbhoy will answer any questions and discuss any procedures, concerns and goals with you in regard to the benefits, methods, alternatives, consequences, risks, and possibility of additional charges. You may withdraw consent to a procedure at any time. With any procedure, there are risks involved which include, but are not limited to scarring, discoloration, infection, bleeding, and nerve damage.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures. I do not impose any limitations on Denton Dermatology and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore; with my signature, agree to have any necessary procedures performed.

✕ _____ _____

Patient Signature **Date**

HIPAA CONSENT

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices which has been made available for review by the patient.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family or friends? ☐ YES ☐ NO

If YES, please name the people allowed.

Name and Relationship to Patient	**Phone**
Name and Relationship to Patient	**Phone**

✕ _____ _____

Patient Signature **Date**

OFFICE POLICIES

1. We strive to be on schedule for your appointment and we appreciate your timeliness as well. You must arrive at least 15 minutes prior to your appointment for registration, regardless if you are an established or new patient. If you need to cancel or reschedule an appointment, it must be done at least 24 hours in advance in order to avoid a $50 cancellation fee.

2. Although we will handle the billing for the insurance plans with which we're contracted, each patient must take responsibility for knowing what his/her insurance coverage entails. The majority of procedures performed are surgical in nature and may be subject to a deductible and/or coinsurance in addition to your copay. Some examples are destruction of lesions with liquid nitrogen or other chemicals and injections. A separate bill may be sent for additional charges from the Pathologist or Laboratory. Any charges deemed "non-covered" or "out-of-network" by your insurance company will be your responsibility.

3. MEDICAID requires its participants to see Medicaid-approved providers. Since we are NOT providers for Medicaid, we will NOT be able to provide services to you.

4. No post-dated checks are allowed. There will be a $35 charge for all returned checks. If your account becomes delinquent and is turned over to a collection agency, you will be responsible for all collection costs (up to an additional 50% of delinquent balance).

5. REFERRALS: if your insurance plan requires a referral, you must obtain this from your primary care physician. An office referral is not the same as an insurance referral. This insurance referral (with authorization number, etc) must be received before your appointment date. It is your responsibility to know if you need a referral, when that referral expires, and how many visits have been authorized.

6. Medication refills may be requested through your pharmacist, who will in turn receive approval or denial from the doctor. This could take up to 2 business days. Your signature below also authorizes us to view your prescription history.

7. Phone calls will be returned as soon as possible. Please understand that our primary responsibility is caring for patients currently in the office. The medical assistant will inform you of your test results, usually within 7 days after your procedure.

These policies exist in order to better serve you. By signing below, you are acknowledging that you have read and understand the policies listed above.

I authorize the release of any medical or other information necessary to collect balances and/or process claims from this office. I also authorize payment of medical benefits to the physician for the services described. I understand that payment for procedures that are deemed not medically necessary is due at the time of service and will not be billed to insurance. I also understand that copays, co-insurance, and deductibles will be paid by me at the time of service. Any amount remaining unpaid/unprocessed by my insurance company after 60 days following the date of service will also be my responsibility. I will make this payment in the form of cash, check or credit card (we do not take CareCredit).

Signature of Patient or Parent/Guardian:_____

Printed Name:_____ Date: _____

Patient Name (if different from above): _____