



REGISTRATION FORM

(Please Print)

Primary Care Physician's Name:
Name of Physician Referring You:

Today's Date:

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____

Mr. Miss Marital status (circle one)
 Mrs. Ms. Single / Mar / Div / Sep / Wid

Is this the name on your insurance card? If not, what is the name on your insurance card?
 Yes No

Patient's Birth date: Age: Sex:
 / / M F

Street address: Social Security #: Home phone #:
 ()

P.O. box: City: State: ZIP Code:

Patient Occupation: Patient Employer: Employer phone #:
 ()

E-mail Address: Cell Phone #: ()

INSURANCE INFORMATION

(Please complete this section and then give your insurance card to the receptionist when you are finished.)

Person to Receive Bills: Their Birth date: Is person a patient here: Their Home phone #:
 / / Yes No ()

Mailing Street Address for Bill (if different from patient): City State ZIP Code

Their Occupation: Their Employer: Their Employer's address: Employer phone #:
 ()

Is this patient covered by insurance? Yes No

Name of primary insurance plan:

Subscriber's name: Subscriber's S.S. #: Subscriber's Birth date: Group/Account #: ID #: Co-payment:
 / / \$

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance plan (if applicable):

Subscriber's name: Subscriber's S.S. #: Subscriber's Birth date: Group/Account #: ID #:
 / /

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone #: Work phone #:
 () ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the Dermatology & Laser Center at Harvard Park, PLLC or my insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Medical History

Patient: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications: YES NO

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction? YES NO

Do you now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO	Other Systemic:	YES	NO
Lungs:					
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
			Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection		
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Leg Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
			Depression	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases/conditions: _____

Do you take ginkgo, garlic or ginseng? YES NO
Have you ever had or been exposed to Tb? YES NO

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

Skin: Have you ever had skin cancer? YES NO
Has anyone in your family had skin cancer? YES NO
Do you have a history of any specific skin diseases? YES NO If YES, _____
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: Medications Food Environment Bandages Topical Neosporin
 Other _____

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day
Do you smoke? YES NO If YES, how much? _____
Have you had or have you been exposed to HIV (AIDS)? YES NO

Please answer the following question:

(Women) Are you pregnant? YES NO Due Date: ___/___/___
Completed by: Patient Medical Assistant _____ Initials Other _____

_____/_____/_____
Patient or Guardian Signature Date Reviewed by Date



Notice and Acknowledgement

Acknowledgement:

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Print Patient Name

Personal Representative Name (if applicable)

Patient or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

Patient Consent for Disclosure of Protected Health Information

With this consent, the Dermatology & Laser Center may leave messages, as indicated below, with my confidential medical information to assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items and any information pertaining to my clinical care, including laboratory and pathology results.

I authorize the practice to disclose the confidential medical information via:

Home phone number (answering machine) _____

Cell phone number (voicemail) _____

Work phone number (voicemail) _____

Other individual (please give name, relationship, and contact number) _____

I may revoke my consent in writing at any time, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Date

Print Patient's Name

Print Name of Legal Guardian (if applicable)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Sharon Kluk. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, (*12.00 for first ten pages and 25 cents for every page after ten*) for each page and the staff time charged will be

\$ (25.00) per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (*Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.*)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Dermatology and Laser Center at Harvard Park, PLLC

Privacy Officer: Sharon Kluk

Phone: 303-744-2704 Fax: 303-744-3244

Address: 950 E Harvard Ave, Suite 440, Denver CO 80210

NEW PATIENT SURVEY

Please let us know how you heard about our practice.

- | | |
|--|---|
| <input type="checkbox"/> Family Member(s) | <input type="checkbox"/> Friend(s) or Acquaintance(s) |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Our Web Site (www.DLCderm.com) |
| <input type="checkbox"/> PCP Office | <input type="checkbox"/> DexMedia Web Site (www.dexonline.com) |
| <input type="checkbox"/> Other Physician Office | <input type="checkbox"/> Other Web Site _____ |
| <input type="checkbox"/> Phone Book Yellow Pages (Dermatology Section) | |
| <input type="checkbox"/> Phone Book Yellow Pages (Skin Care Section) | |
| <input type="checkbox"/> Phone Book White Pages | |
| <input type="checkbox"/> Other _____ | |

Please Print Patient Name