GERMAIN
DERMATOLOGY

NEW PATIENT REGISTRATION FORM

Last Name:	First Name:	M.I.
SSN:	Date of Birth:	Sex: Male ❒ Female ❒
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed		Race:
Mailing Address:		
City:	State:	Zip:
Employer:	Occupation:	

Home Phone _____ -_____ -_____ Cell Phone_____ -_____ -_____

Work Phone _____ -_____ -_____ Email _____

By providing my wireless telephone number, I am consenting to receiving communications via calls or text messages including but not limited to information regarding appointments, payments, prescriptions, labs, and pathologies.

By providing my email address, I consent to receiving statements, bills, and marketing material for dermatology and cosmetic services via email.

Signature: _____ **Date:** _____

How did you hear about us?

- ○ Google
- ○ Social Media: _____
- ○ Patient/Physician: _____
- ○ Other Advertisement: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____- _____- _____

Insurance Information:

Primary Insurance Name: _____
Policy Number: _____
Policy Holder's Name: _____
Policy Holder's DOB: _____

Secondary Insurance Name: _____
Policy Number: _____
Policy Holder's Name: _____
Policy Holder's DOB: _____

I hereby authorize the physician to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original. I also give consent for my photo to be taken and used as part of my plan of treatment and confidential medical record.

Patient/Legal Guardian Signature: _____ **Date**: _____

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Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Germain Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Germain Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Germain Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Germain Dermatology at 612 Seacoast Parkway, Mount Pleasant, South Carolina, 29464.

With this consent, Germain Dermatology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Germain Dermatology, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Germain Dermatology, may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Germain Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Germain Dermatology's use and disclosures of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Germain Dermatology may decline to provide treatment to me.

Print Name of Patient or Legal Guardian	Date of Birth
Signature of Patient or Legal Guardian	Date

Flip to back side!!

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Please Initial:

_____ I understand and agree to the terms of Germain Dermatology's Photo, Financial, Late Policy & Pathology Policy.

Consent to Share Information

I authorize Germain Dermatology to disclose medical information pertaining to payments, insurance, diagnosis, and my personal health to the following persons:

	Name	Relationship to Patient	Phone Number	Leave a Message
(Primary)	_____	_____	_____	☐Yes ☐No
(Other)	_____	_____	_____	☐Yes ☐No

*The above will stay in effect until voided by you.

Prescription History Consent

Germain Dermatology is enrolled in an electronic prescribing program. This program is meant to help our providers understand what medications our patients are currently using in order to provide the best possible treatment. By signing this consent form, you are agreeing that Germain Dermatology may request and use your prescription history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Germain Dermatology enroll me in the ePrescribe program.

_____
Signature of Patient or Legal Guardian

Are you covered by any other insurance that makes Medicare secondary? ☐Yes ☐No

If Medicare is your secondary insurance, please circle the type of coverage you have:

1. Working Aged/Spouse Group Plan
2. ESRD
3. No Fault/Auto Primary
4. Worker's Comp
5. Public Health Service/ Other Fed Agency
6. Veteran's Admin
7. Disabled
8. Beneficiary Under age 65
9. Other Liability Ins is Primary
10. Black Lung

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job?

☐Yes ☐No

_____
Print Name of Patient or Legal Guardian

_____
Date of Birth of Patient

_____
Signature of Patient or Legal Guardian

_____
Date

Germain Dermatology Cosmetic Medical History

Patient: _____ Date of Birth: ____/_____/_____ Chart#: _____

Do you have now or have you ever had any of the following past medical history?

	Y	N		Y	N		Y	N
Abnormal Bleeding/Bleeding Disorder	□	□	Lupus/SLE	□	□	Seizures/Fainting/Epilepsy	□	□
Anxiety/History of Anxiety	□	□	Pacemaker/ Defibrillator	□	□	***Please Specify_____**		
Hernia	□	□	Stroke	□	□	Other Medical Condition	□	□
High Blood Pressure	□	□	Fever Blisters/Cold Sores/Herpes Simplex	□	□	***Please Specify_____**		

Are you allergic to any medications? □ y □ n **If yes, list below:**

1._____2._____3._____

Please list all current medications and dosage (ie: prescriptions, acne medications, OTC medications, and vitamins):

1._____2._____3._____

4._____5._____6._____

Are you allergic to any of the following?

Local Anesthetic (lidocaine) □ y □ n Latex □ y □ n Adhesive Tape □ y □ n

Smoking History

□Current every day smoker □Former smoker
Current some day smoker □Never smoker

FEMALE PATIENTS ONLY

Are you pregnant? □ y □ n

Are you nursing? □ y □ n

Are you trying to become pregnant? □ y □ n

What is your reason for being seen today?_____

Patient Signature (or authorized representative): _____
Date ___/___/___

Pharmacy Name: _____ Phone: _____

Aesthetic Patient Self Assessment

Please complete this questionnaire to help us better understand your history, preferences, and concerns with respect to aesthetic treatments and procedures. Your responses will help us identify and recommend the most appropriate treatments and procedures for you.

Patient Name:_____ Date:_____

What is your reason for your visit today?

_____

_____

What aesthetic treatments, surgeries, procedures, if any, have you had in the past?

_____

_____

If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome?
___ Yes ___ No If no, in what way were you dissatisfied?

_____

_____

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

☐ Skin care products	☐ Botox/Dysport	☐ Fat Bulges
☐ Injectable treatments	☐ Facial veins	☐ Under Chin Fat (Double Chin)
☐ Facial fine lines/wrinkles	☐ Facial redness/Rosacea	☐ Body Contouring
☐ Thin lips	☐ Brown spots/age spots/freckle	☐ Unwanted Hair
☐ Blotchy skin	☐ Drooping brow	☐ Length/Fullness of Eyelashes
☐ Facial peels	☐ Drooping eyelids	☐ Stretch Marks
☐ Make Up	☐ Facial fullness/drooping	☐ Acne
	☐ Scar(s)	☐ Dermal Fillers
	☐ Neck wrinkles	

How did you hear about us?

☐ My physician	Full Name of Physician:
☐ My insurance company provider	Name of Company:
☐ The yellow pages	
☐ A friend or family member	Name of Friend/Family Member:
☐ Internet	Website Address:
☐ Billboard	Date/Location of Seminar:
☐ Skirt Magazine	
☐ TV	
☐ Approval to contact you	Best phone number to reach you:
☐ Approval to send you information on products and services (including special offers)	Email address:

☐ I'm not interested in any additional services provided at this time.

Skin Typing...

		1	2	3	4	5
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
	What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, chestnut brown	Dark brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

My ethnic origin is closest to:

**Very Fair (Celtic and Scandinavian)*
**Fair Skinned Caucasian with light hair and light eyes*
**Pale-skinned Caucasian with dark hair and dark eyes*
**Olive-skinned (Mediterranean, some Asian, some Hispanic)*
**Dark skinned (Middle Eastern, Hispanic, Asians, some African)*
**Very dark-skinned (African)*

For office use only:

Add above for Total score:	Match your total score with the corresponding Skin Type.	Fitzpatrick Skin Type:
	0-7	I
	8-16	II
	17-25	III
	26-30	IV
	Over 30	V-VI