Glenn Yarbrough, MD

Kendall Jenson PA-C **Darren West PA-C**

Patient Registration & Medical History

Date: ____________________

PATIENT INFORMATION

Name ____ **SS#** ______________
LAST FIRST MIDDLE

Date of Birth ________________ **Gender** ____________ **Marital Status** ❑ Single ❑Married ❑Divorced ❑Widowed

Address 1 ______________________________ **City** __________ **State** _____ **Zip** _______

Address 2 ______________________________ **City**__________ **State** _____ **Zip**_______

Phone *(check ☑ preferred contact number)*:
Home ❑ ____________________ **Cell**❑ ______________ **Work**❑ ______________

Email ________________________ **May we send information to you at this email address?** ☐Yes ☐No
We promise never to share, trade, sell, or market your email address

Employer__________ **Employer's Address** ______________________________________
STREET CITY STATE ZIP

Primary Care Physician ______________________________ **PCP Phone** ________

Referring Physician ❑PCP or ❑Other Physician Name____________________ Phone ____________

If not referred, how did you hear about us? ❑Website ❑Physician ________ ❑ E-Newsletter ❑ Current Patient ❑Other ________

Pharmacy ____________________ **Phone**__________ **Address**______________
Our practice utilizes e-prescribing. Prescriptions are sent electronically to the pharmacy of your choice for safety and convenience.

Scottsdale Dermatology has my permission to give Biopsy/Lab Results or other messages:

❑ To Me ❑ To other family members ❑ All of the options
❑ To my Spouse ❑ On my answering machine

GUARANTOR (*If Guarantor is the Patient, Check Here ❑ and Skip to Next Section*)

Last Name: ____________________ **First:** ____________ **MI:**_____ **Date of Birth:** _____/_____/_____

Address: ______________________________**City:**______________ **State:** ____ **Zip:**________

Home Phone:________________ **Work Phone:**__________________ **SS#:**________________

Sex: ______________ **Marital Status:**______________ **Occupation:**____________________

Relationship to Patient: ❑**Spouse** ❑**Parent** ❑**Legal Guardian**

INSURANCE *Please present insurance card(s) with this completed form*

Primary Insurance: ______________________________ **Policy Holder:** ____________________

Relationship to Patient: ❑Self ❑Spouse ❑Parent ❑Other **Date of Birth:** ____/____/______ **SSN:** ______________

Employer's Name: ________________________ **Policy#:** ______________ **Group#:**______________

Secondary Insurance: ______________________________ **Policy Holder:** ____________________

Relationship to Patient: ❑Self ❑Spouse ❑Parent ❑Other **Date of Birth:** ____/____/______ **SSN:** ______________

Employer's Name: ________________________ **Policy#:** ______________ **Group#:**______________

If you are over 65 and Medicare is secondary, please list reason: ______________________________

EMERGENCY CONTACT

Name: ________________________ **Phone:** (_____)_____-_______ **Relationship:** ____________

Name: ________________________ **Phone:** (_____)_____-_______ **Relationship:** ____________

These questions are included to comply with new Federal Health guidelines -- we are required to ask for this information.				
	Ethnicity *(check one)*	❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑ Unspecified
	Race *(check one)*	❑ American Indian/ Alaskan Native	❑ Asian	❑ Native Hawaiian/ Other Pacific Island
		❑ Black/African American	❑ White	❑ Unspecified
	Preferred Language *(check one)*	❑ English	❑ Spanish	❑ Unspecified

Patient Name: ______________________________ **DOB:** ________________

MEDICATIONS

(please list all prescription & over-the-counter medications you are taking, including herbs, vitamins & supplements – a long with the dosage)

If you currently DO NOT TAKE ANY MEDICATIONS, check this box: ❑

1) ______________________	**5)** ______________________
2) ______________________	**6)** ______________________
3) ______________________	**7)** ______________________
4) ______________________	**8)** ______________________

MEDICATION ALLERGIES/REACTIONS *(please list medication and associated allergic reaction)*

If you have NO KNOWN MEDICATION ALLERGIES, check this box: ❑

1) ______________________	**4)** ______________________
2) ______________________	**5)** ______________________
3) ______________________	**6)** ______________________

SMOKING STATUS *(check one)*

❑ Never been a smoker ❑ Former smoker ❑ Current sometimes smoker ❑ Current every day smoker

CURRENT/PREVIOUS MEDICAL CONDITIONS

REASON FOR TODAY'S VISIT:____

____

Please check ☑ Yes or No, if you have now, or have ever had diseases or conditions of:

LUNGS			VASCULAR			STOMACH		
Bronchitis	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Bowel	❑Yes	❑No
Emphysema	❑Yes	❑No	Chest Pain	❑Yes	❑No	Hepatitis or Yellow Skin	❑Yes	❑No
Asthma	❑Yes	❑No	Heart Attack	❑Yes	❑No	Glaucoma	❑Yes	❑No
Chronic Cough	❑Yes	❑No	Irregular Heart Beat	❑Yes	❑No			
Morning Cough	❑Yes	❑No	Pacemaker	❑Yes	❑No			
			Phlebitis	❑Yes	❑No			

OTHER SYSTEMIC						IMMUNE SYSTEM		
Diabetes	❑Yes	❑No	Arthritis/Joint Deformity	❑Yes	❑No	Organ Transplant	❑Yes	❑No
Thyroid	❑Yes	❑No	Convulsions, Epilepsy or Seizures	❑Yes	❑No	HIV	❑Yes	❑No
Kidney	❑Yes	❑No	Fainting	❑Yes	❑No			
Bladder	❑Yes	❑No	Allergies (Asthma, Hay Fever, Eczema)	❑Yes ❑No				

Do you drink alcohol?	❑Yes	❑No	If yes_________ drinks per day.	❑ Occasionally
Do you use IV drugs?	❑Yes	❑No	If yes, What?_________________________	How much?___________________
Do you smoke?	❑Yes	❑No	If yes, What?_________________________	How much?___________________

SKIN

When you are exposed to sun do you?	❑Tan only ❑Tan and Burn ❑Burn
Have you ever had skin cancer?	❑Yes ❑No
Has anyone in your family had any specific skin diseases?	❑Yes ❑No

If yes, please list:____

List any other diseases or conditions we should know about:______________________________

____

Do you bleed easily?	❑Yes ❑No	
(Women) Are you pregnant?	❑Yes ❑No	Due Date:______________________
Do you have an artificial joint(s)?	❑Yes ❑No	
What is your occupation?	______________________________________	

Forms Completed by:

❑Patient

❑Other_________
Initials

Patient Name: ____ **DOB:** ___________________

PREVIOUS SURGERIES

____________________________________ Date: ____________ ___________________________________ Date: ______________

____________________________________ Date: ____________ ___________________________________ Date: ______________

CONSENT TO THE USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

I hereby consent to the use and disclosure of personal health information by Scottsdale Dermatology, LTD., its workforce, and its business associates for the purposes of carrying out treatment, health care operations, and obtaining insurance payment. *A copy of the Notice of Privacy Practices for Protected Health Information (Privacy Notice) has been made available to me and it describes my rights as well as the potential uses and disclosures of my protected health information by Scottsdale Dermatology, LTD.*

- You have the right to revoke this consent at any time by notifying the office in writing, except to the extent the office has taken action and reliance upon your consent.
- You have the right to request to restrict the manner in which your protected health is used. The office is not required, however, to agree to such requested restrictions. If the office agrees to the requested restriction, our office will honor the request and it will be binding.
- We have reserved the right to change the privacy practices described in the Privacy Notice in accordance with the law.
- You may obtain a copy of the Privacy Notice and revisions by making such request in writing or in person at our office.

____ _____________________________**20**_____

PATIENT OR GUARDIAN'S SIGNATURE **DATE**

RELEASE OF PROTECTED HEALTH INFORMATION

Do you authorize this office to discuss your care or treatment with any parties besides yourself? ❑No ❑Yes

If YES, list name and relationship to you: ___________________________________ ___________________________

___________________________________ ___________________________

RELEASE AND ASSIGNMENT

I, the undersigned have insurance coverage with____
and assign directly to Scottsdale Dermatology, LTD. all medical benefits. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I am responsible to pay any deductible and/or co-payment and non-covered services under the terms of my insurance. I understand that any payments, which are due, starting 30 days after insurance coverage has been completed, will be charged a $3.00 monthly late service charge: (or) at a rate of 1.5% interest per month on unpaid balance, whichever is larger. I understand that I am financially liable in the event of non-payment: I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

____ _____________________________**20**_____

INSURED OR GUARDIAN'S SIGNATURE **DATE**

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits to be made directly to Glenn Yarbrough, M.D., on my behalf for any service furnished by that physician. I authorize any holder of medical information about me to release to CMS and its agents needed to determine these benefits payable for related services. I understand my signature request that be made and authorize release *of* medical information necessary to pay claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible for deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

____ _____________________________**20**_____

BENEFICIARY'S SIGNATURE **DATE**

NON-INSURANCE (CASH) AND / OR COSMETIC PATIENTS

I understand that payment in full is expected at Time of Service for all services performed by Scottsdale Dermatology, LTD. I also adhere to the current policy of Scottsdale Dermatology, LTD. regarding collection fees incurred to collect balance in full.

____ _____________________________**20**_____

PATIENT OR GUARDIAN'S SIGNATURE **DATE**

Patient Name: ______________________________________ **DOB:** __________________

INSURANCE ASSIGNMENT AND FINANCIAL POLICY

Please read and sign this statement before we agree to accept assignment of benefits directly from your insurance company. This avoids any misunderstandings and facilitates the processing of your insurance claim.

PAYMENT POLICY

MEDICARE: We are participating providers of the Medicare program. We will accept assignment of all claims. Patients are responsible for meeting their annual deductible and co-pays at the time of service. We do file with secondary supplement carriers.

HMO, PPO, or OTHER MANAGED CARE PATIENTS: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services at the time of service. Patients without the required referral from your PCP at the time of appointment will be asked to reschedule. If you prefer to be seen without the required referral, payment will be due at the time of service.

COMMERCIAL PATIENTS: Patients who are covered by private, commercial plans, in which our physician is not contracted, are responsible for all fees. The balance left after payment from your insurance will be billed to you.

CANCELLATION POLICY

I understand and agree that I will give at least a 24 hour notice if I am unable to make a scheduled appointment. A charge of $30.00 will be assessed to my account for missed or broken appointments without a 24 hour notice.

INSUFFICIENT FUND/RETURNED CHECK POLICY

I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payment on my account thereafter and I will be obligated to pay a returned check fee of $30.00.

PAYMENT IS DUE AT THE TIME OF SERVICE

I understand that office visit charges are payable on the day service is rendered. I authorize Scottsdale Dermatology, LTD to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Glen Yarbrough and myself. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand I am financially liable in the event of non-payment: I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

____ ____________________________20_____

PATIENT OR GUARDIAN'S SIGNATURE **DATE**

____ ____________________________20_____

STAFF SIGNATURE **DATE**