STONE DERMATOLOGY PATIENT REGISTRATION FORM PH. 586 685-3285

Thanks for choosing Stone Dermatology. Please help us with your first visit on _____ at _____ by completing the following information. If you need help the receptionist will be happy to assist. **The office is located at 14460 Lakeside Circle, Suite 100 in the Bank of America Building directly across the parking lot from Lord & Taylor at Lakeside Mall. The location is on the south side of the mall circle road opposite Hall Road.**

PATIENT LAST NAME _____ FIRST NAME _____ MIDDLE NAME OR INITIAL _____ AGE _____

ADDRESS _____ UNIT# _____ CITY _____ STATE _____ ZIP CODE _____

PHONE H_____ C_____ W_____ EMAIL_____

(Please circle preferred phone contact. This number will be called for appointment reminders)

DATE OF BIRTH Month_____ Day_____ Year_____ SEX (M) (F) MARTIAL STATUS (S) (M)

PATIENT'S SOCIAL SECURITY #_____ _____ _____. OCCUPATION _____

EMPLOYED BY:_____

EMERGENCY CONTACT_____ RELATIONSHIP _____

PHONE # H_____ C_____ W_____

PHARMACY INFORMATION (NOW REQUIRED FOR ELECTRONIC PRESCRIPTIONS)

PHARMACY NAME: _____ PHONE #_____

PHARMACY ADDRESS:_____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME _____ POLICY HOLDER OR NAME OF PERSON RESPONSIBLE FOR BILL _____

SOC SEC # OR INSURANCE # OF THIS PERSON _____ DATE OF BIRTH _____ GROUP # _____

SECONDARY INSURANCE PLAN NAME _____ POLICY HOLDER OR NAME OF PERSON RESPONSIBLE FOR BILL _____

SOC SEC # OR INSURANCE # OF THIS PERSON _____ DATE OF BIRTH _____ GROUP # _____

HOW DID YOU CHOOSE THIS PRACTICE?

PLEASE CIRCLE ALL THAT APPLY RECOMMENDED BY FRIEND OR FAMILY YELLOW PAGES OR INTERNET

INSURANCE PHYSICIAN REFERRAL PHYSICIAN NAME_____PHONE_____

ADDRESS_____

PLEASE PROVIDE DRIVERS LICENSE AND INSURANCE CARDS AT TIME OF VISIT FOR IDENTITY VERIFICATION

Stone Dermatology Medical History Form

Patient Name Last First MI

Age **Birthday:** Month Day Year

Please complete the following information concerning your health status.

Reason for Visit _____

MEDICATIONS: Please list all medication that you are currently taking.

ALLERGIES: YES___ NO___ Please list allergies or medications that cause allergic reactions.

Have you been told to premedicate for dental or surgery procedures? Yes___ No___

Could you be pregnant now or are you breast feeding? Yes___ NO___ Male___

Check the box that best describes your medical condition.

Condition or Diseases	Never	Prior	Current	Condition or Diseases	Never	Prior	Current
Aids \ HIV Positive				Kidney Disease			
Arthritis\Bone\Joint				Lupus			
Asthma				Lung or Respiratory			
Bleeding Tendencies				Neurological / seizures			
Cancer				Psychiatric			
Circulation Problems				Psoriasis			
Coronary Heart Disease				Sexually Acquired Dis.			
Diabetes				Skin Cancer			
Eye Disease				Stomach / Digestive			
Hair Loss (Sudden)				Stroke			
Headaches				Thyroid Problem			
Hepatitis				Tuberculosis			
Herpes				Urinary Tract Disease			
High Blood Pressure				Other			
Hives				Other			

HOSPITAL OR SERIOUS INJURIES: Please list major surgeries, hospitalizations or serious injuries.	Year

MARITAL STATUS S__ M__ W__ D__ Sep__ Can you care for yourself? YES NO

TOBACCO USE Never___ Prior___ Daily___ Packs per day

DRUGS USE Never___ Yes___ Type and Frequency

ALCOHOL USE No___ Yes___ Number of Drinks per Day___ Week___

SKIN IRRITANT EXPOSURE No___ Yes___ Type and Frequency

FAMILY HISTORY Please list family members with skin disease.

Relation	Age	Disease	Cause of Death

Reviewed & Updated by:			Signature:	Date:	
Signature:	Date:		Signature:	Date:	
Signature:	Date:		Signature:	Date:	

Form 3 Jan. 10, 2002

RICHARD A. STONE, M.D.

14460 Lakeside Circle Suite 100
Sterling Heights, MI 48313
586.685.3285

Print Patient Name | Date of Birth | Chart#

PLEASE READ CAREFULLY

YOU ARE DIRECTLY RESPONSIBLE FOR PAYMENT OF CARE PROVIDED BY THIS OFFICE

Payments for any uncovered services, cosmetic, and co-pays must be paid at the time of service. This also includes treatments not covered as a contractual benefit, procedures judged to be not medically necessary or any visits where required authorizations or referrals were not obtained. In order to serve you we accept cash, personal checks, Visa, MasterCard Discover and AMEX. We are not permitted to bill your insurance company for procedures that are not covered, including any cosmetic services. We will submit a claim to your insurance for covered procedures to insurance companies that we participate with.

Please note that if a surgical tissue specimen must be sent to be the lab, additional charges to you or your insurance company will be incurred.

Please let us know if you have special financial needs or circumstances.

AUTHORIZATIONS AND ACKNOWLEDGMENTS

1. I have read and understand the payment policy
2. I authorize insurance benefits to be paid, if necessary, directly to the physician
3. I authorize the release of my medical information to my medical insurance carriers.
4. **I authorize the physician, the physician assistant, and staff under the physician's supervision to provide me with reasonable and proper medical care consistent with today's standards to include but not limited to:**
    a. **Diagnosis and treatment.**
    b. **And upon discussion and verbal agreement, surgical procedures of the skin involving, removal, destruction, and application of dermatologic treatment agents.**
5. I acknowledge being offered a copy of the Notice of Privacy Practices.
6. To which family member, if any, can we release your medical information?

Name of family member: _____

Relationship to Patient: _____

Signature of Patient or Responsible Party | Date

Richard A. Stone, M.D.
14460 Lakeside Circle Suite 100
Sterling Heights MI 48313
586.685.3285

Acknowledgment of Receipt of Privacy Practices

I hereby acknowledge receipt of notice of privacy practices, which details the use and disclosure of my protected health information by the offices of RICHARD A. STONE, M. D.

I understand that signing this acknowledgment does not mean that I agree with the contents of the Notice of Privacy Practices.

I understand that I may receive further copies of the Notice of Privacy Practices in the future as revisions are made, or should I require additional copies.

If at any time I have questions concerning the Notice of Privacy Practices, I understand that I may have all my questions answered by contacting the Privacy Officer at the offices of RICHARD A. STONE, M.D. at the above telephone number.

_____ Date: _____
Signature of Patient/ Representative

_____
Printed Name

Witness:

_____
Signature of Witness

_____
Printed Name

If an acknowledgment is not obtained, document below the good faith efforts to obtain the acknowledgement and the reason why it was not obtained:

Patient Name:_____ Date: _____

Reason acknowledgment was not obtained (describe reason, such as an emergency treatment situations or substantial barrier to communication:

_____

_____
Signature of Associate