

<b>Dermatologix, Inc.</b> <b>PO Box 107</b> <b>Linwood, New Jersey 08221</b> <b>PATIENT REGISTRATION</b>	<b>ATLANTIC DERMATOLOGY</b> <b>&amp; LASER CENTER</b>
<b>Patient</b> Last Name _____ MI _____ First Name _____ Age _____ Address _____ City _____ State _____ Zip _____ Home Ph ( ____ ) _____ - _____ Sex: M _ F _ Birth Date _____ Soc. Sec# _____ - _____ <b>Status:</b> Single Married Separated Divorced Widowed	<b>Policy Holder / Insured</b> (Leave blank if same as patient.) Last Name _____ MI _____ First Name _____ Age _____ Address _____ City _____ State _____ Zip _____ Home Ph ( ____ ) _____ - _____ Sex: M _ F _ Birth Date _____ Soc. Sec# _____ - _____ <b>Relationship of Patient to Insured</b> Self Spouse Child

**Employment Status** Full time \_ Part time \_ Employed since \_\_\_\_ / \_\_\_\_ Retired \_  
Not Employed \_ Student \_

Patient Employed by \_\_\_\_\_ Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Work Ph #( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Occupation \_\_\_\_\_

**Insurance Information**

Primary Insurance Co \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_  
Insured/ Policy Holder \_\_\_\_\_ Birth Date \_\_\_\_\_ Referral# \_\_\_\_\_ Visits# \_\_\_\_\_  
Secondary Insurance Co \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_  
Insured/ Policy Holder \_\_\_\_\_ Birth Date \_\_\_\_\_ Referral# \_\_\_\_\_ Visits# \_\_\_\_\_

**Patient Information**

Referred to the office by Dr \_\_\_\_\_ of \_\_\_\_\_ Pharmacy \_\_\_\_\_

How did you hear about our practice?

- The Current: If the current, which edition?
  - Atlantic City Press
  - Linwood/Northfield/Somers
  - Hammonton News
  - Egg Harbor Township
  - Hammonton Gazette
  - Margate, Ventnor, Longport
  - Yellow Pages
  - Ocean City
  - Television
  - Hamilton Twp. & Egg Harbor City
  - Friend
  - Absecon & Galloway
  - Other: \_\_\_\_\_
  - Cape May
  - Middle Twp, Stone Harbor, Avalon

**OFFICE VISITS NOT COVERED BY INSURANCE AND COPAYS ARE PAYABLE ON THE DAY YOU ARE SEEN**

I request that payment of authorized benefits be made either to me or on my behalf to Joseph J Hong, MD for any services furnished to me by Joseph J Hong MD. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Financial Responsibility**

The information is accurate and true to the best of my knowledge, I understand that if my insurance company denies the claim then I am responsible for payment for all services rendered.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# ATLANTIC DERMATOLOGY & LASER CENTER

Please fill out all fields

**Name:** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Sex:**  Male  Female

**Reason for Visit Today:** \_\_\_\_\_

**Past Medical History:** Check if you have been diagnosed with any major medical problems

- Stroke       Kidney Disease       Liver Disease       Eczema       Skin Cancer  
 Glaucoma       High Blood Pressure       GI bleed       Asthma       Basal Cell Carcinoma  
 Arrhythmia       Heart Attack/ Angina       Reflux       Hepatitis       Squamous Cell Carcinoma  
 Tuberculosis       Mitral valve prolapse       Ulcer       HIV/AIDs       Melanoma

**Past Surgical History** (if skin cancer removal, specify location):

Operation (location)	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**Medications:** (list current medications, including **Aspirin** and **Birth Control Pills**)  **NONE**

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**Allergies:** (List medications you are allergic to) \_\_\_\_\_

**Family History – have any relatives been diagnosed with:**

- Squamous Cell Carcinoma       Melanoma       Eczema  
 Basal Cell Carcinoma       Asthma       Psoriasis

Have you ever smoked? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Are you currently pregnant or breast-feeding? \_\_\_\_\_

Are you planning on becoming pregnant in the next 6 months? \_\_\_\_\_

Occupation/ Profession: \_\_\_\_\_

**Review of Symptoms:** (check all that apply)

**Eyes**

- Vision loss
- Blurred Vision
- Corrective Lenses

**Endocrine**

- Excessive thirst
- Hot/cold intolerance
- Skin rash

**Neurological**

- Numbness
- Weakness
- Tremor

**Constitutional**

- Anorexia
- Weight Loss
- Fatigue

**Ears, Nose, Throat**

- Loss of Smell
- Hoarseness
- Hearing Loss

**Gastrointestinal**

- Nausea
- Vomiting
- Abdominal Pain
- Black stools
- Indigestion
- Jaundice

**Hematological**

- Swollen glands
- Prolonged bleeding
- Easy bruising
- Frequent Infections

**Gynecological**

- Irreg. Periods
- Excessive Cramps
- Excessive Bleeding
- I could be pregnant
- Date of Last Period \_\_\_\_\_

**Cardiovascular**

- Chest Pain
- Heart Attack
- Heart murmur
- Pacemaker
- Artificial valve

**Musculoskeletal**

- Joint swelling
- Back pain
- bone pain
- Excessive thirst
- Artificial Joint

**Psychiatric**

- Anxiety
- Suicidal
- Psychosis
- Numbness

**Respiratory**

- Wheezing
- Cough
- Shortness of breath
- Anorexia

PATIENT SIGNATURE : \_\_\_\_\_ DATE : \_\_\_\_\_

**Individual Patient Authorization**

I give my authorization to use or disclose my health information to the following people and organizations:

The staff of Atlantic Dermatology and its billing company

My insurance company(ies) and their representatives

Other physicians involved in my health care

My pharmacy

My spouse \_\_\_\_\_  
spouse's name

My child(ren) \_\_\_\_\_  
child(ren)'s name(s)

Other \_\_\_\_\_  
(please specify)

**Patient Communications**

**Home Phone**

Atlantic Dermatology may leave a message on my home phone with detailed information.

Atlantic Dermatology may leave a message on my home phone with call back number only.

**Work Phone**

Atlantic Dermatology may leave a message on my home phone with detailed information.

Atlantic Dermatology may leave a message on my home phone with call back number only.

**Written Communications**

Atlantic Dermatology may send mail to my home address.

Atlantic Dermatology may send mail to my work address.

Atlantic Dermatology may send a fax to me at my request.

**Revoking Authorization**

I understand that I may revoke this authorization at any time by given written notice to Atlantic Dermatology. However, I understand the revocation will not be effective for any actions taken prior to receipt of the written notice. I understand that I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke the authorization, the insurance company may contest my claims under the policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_