TARANTOLA DERMATOLOGY
SKIN CANCER EXPERTS

**PATIENT REGISTRATION** **APPOINTMENT DATE:**

Name: _____ Date of Birth: _____

Gender: M or F SS# _____ Age: _____ Marital Status: (Circle One) S M W D Sep

Language: _____ Race: _____ Ethnicity: (Circle One) Hispanic/Not Hispanic

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W)_____ (Cell) _____

e-mail: _____

Patient's Occupation/Employer: _____

Spouse's Name: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Physician: _____ Referred by: _____

**INSURANCE AND BILLING INFORMATION**

**PRIMARY INSURANCE**

Subscriber: _____ Relation: _____ DOB: _____

Insurance Company: _____

**Contract Number/Member ID/Policy Number:** _____

**Group Number:** _____

**Name of Employer, if group insurance:** _____

**SECONDARY INSURANCE**

Subscriber: _____ Relation: _____ DOB: _____

Insurance Company: _____

**Contract Number/Member ID/Policy Number:** _____

**Group Number:** _____

**Name of Employer, if group insurance:** _____

**** Photo ID and ALL health insurance cards are required at each visit. ****

Form Update 10/19/2023

**(OVER)**

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525 Brent Lane
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Name: _____ Date of Birth: _____

## PAYMENT POLICY

This practice is a participating provider for AETNA, Alabama Blue Shield, Cigna, Cigna Healthspring, Florida Blue Shield, Humana, Humana Gold Choice, Medicare, Tricare, United Healthcare, Wellcare and other insurance companies. Some insurance policies require a referral and/or authorization PRIOR to being seen. It is the patient's responsibility to make sure the practice has a current referral and/or authorization on file. Patients are responsible for all deductibles, co-insurances and co-pays as required by the participating plan.

If you do not have one of the above plans, all charges are payable at the time services are rendered. We will file an insurance claim for your reimbursement or provide you with a copy to file.

For surgical fees, please consult with the front office regarding payment.

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Tarantola Dermatology, Inc. for services rendered in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Signature: _____ Date: _____

## AUTHORIZATION TO RELEASE INFORMATION INCLUDING ELECTRONIC TRANSFER

I hereby authorize Tarantola Dermatology, Inc. to release any medical information that may be necessary for either medical care or in processing applications for insurance benefits. I also authorize the release of any medical information that may be necessary for treatment, diagnosis and/or coordination of care between Tarantola Dermatology Inc., any physician taking call for TDI, a referral physician and to include e-prescription and/or electronic transfer of information to patient's referring physician, primary care provider or referral physician.

Signature: _____ Date: _____

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## PATIENT MEDICAL HISTORY

**Name:** _____ **DOB:** _____ **Today's Date:** _____

**Primary Care Physician:** _____ **Dermatologist:** _____

**Race:** _____ **Ethnicity:** Hispanic **OR** Non-Hispanic/Latino **Language:** _____

**Height:** _____ **Weight:** _____ **Email:** _____

**Pharmacy Information**: (If unable to provide address or phone number, please provide cross streets.)

Name: _____

Address: _____

City: _____ State: _____ Phone #: _____

**MEDICAL HISTORY**

**List any *prior* medical illness:**

| | |
|---|---|
| | |
| | |
| | |
| | |

**CIRCLE any of the following that are *presently* applicable:**

| | | |
|---|---|---|
| HIV/AIDS | Hepatitis B/C | Constipation |
| Irregular heart rate/ AFIB | Stents in your heart | High Blood Pressure |
| Heart Disease | Heart Attack | Stroke/TIA |
| Shortness of breath | COPD/Emphysema/Asthma | Seizures |
| Organ Transplant | Leukemia/Lymphoma | Cancer (other than skin) |
| Liver Disease | Diabetes I/II | Bleeding tendencies |
| Vision Changes | **Pacemaker/Defibrillator** | Staph Infection/MRSA |
| Healing problems/Keloids | Enlarged lymph nodes/glands | Unexplained weight loss |
| Thyroid Problems | Immunosuppression | Sore Throat |
| Abdominal Pain | Joint Pain | Muscle Weakness |
| Anxiety | Depression | Dementia/Alzheimer's |

Do you need antibiotics before dental work or during procedures? ___ No ___ Yes
Do you have artificial joints or are you scheduled for a joint replacement in the next 4 weeks? ___ No ___ Yes
Female only: Could you be pregnant? Are you breastfeeding? ___ No ___ Yes
***For patients 66 and older: Have you received a pneumonia vaccination? ___ No ___ Yes**
***Do you have a health care proxy in the event you are unable to make your own medical decisions? ___ No ___ Yes**
Do you have a living will? ___ No ___ Yes Name of your health care proxy: _____

**List all prior surgeries:**

| | |
|---|---|
| | |
| | |

**Recent hospitalizations (within last 12 months):**

| | |
|---|---|
| | |



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**SKIN DISEASE HISTORY**

| Do you have a history of: | | | |
|---|---|---|---|
| | Melanoma | No | Yes |
| | Basal Cell Carcinoma | No | Yes |
| | Squamous Cell Carcinoma | No | Yes |
| | Acne | No | Yes |
| | Actinic Keratosis/Precancers | No | Yes |
| | Eczema | No | Yes |
| | Psoriasis | No | Yes |
| | Flaking/Itching Scalp | No | Yes |
| | Precancerous Moles | No | Yes |

Has any first-degree relative had any of the above conditions? No Yes

If YES, Which Relative: _____ Condition: _____
Which Relative: _____ Condition: _____
Which Relative: _____ Condition: _____

**LIST ALL CURRENT MEDICATIONS** (INCLUDING SUPPLEMENTS/VITAMINS/HERBAL MEDICINES)

| NAME OF MEDICATION<br><br>Ex: Tylenol | STRENGTH<br><br>500 mg | ROUTE<br><br>Orally | FREQUENCY<br><br>Every 4-6 hours, as needed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |
| | | | |

**Are you currently taking any blood thinners (Plavix, Pradaxa, Warfarin, Coumadin, Aggrenox, Xarelto, aspirin, fish oil, Vitamin E, garlic, gingko, ginger, ginseng)**

☐ No ☐ Yes (please circle)

**MEDICATION ALLERGIES**: ☐ No ☐ Yes (please list name and reaction)

| | |
|---|---|
| | |
| | |

**SOCIAL HISTORY**

Occupation: _____ Retired (year): _____

**Smoke:** ☐ **No** **Year Quit:**_____ ☐ **Yes** **How many packs a day?** _____

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# FINANCIAL POLICY

**Our Financial Policy:** We would like to thank you for choosing Tarantola Dermatology Inc. for your dermatologic medical needs. Our goal is to provide you with exceptional health care services and make every visit a positive experience. We have written this to keep you informed of our current financial policies. We realize this information may not always address your specific situation and encourage you to contact our office whenever you have any questions or concerns regarding your account.

**Credit Card Policy:** We accept MasterCard, Discover and Visa & AMEX for your charges. There is a 3% processing fee for using credit cards. Debit cards are no charge.

**Insurance Usual and Customary:** We are a provider for many insurance companies; therefore, we adjust our charges to their allowed amount.

**Our Policy:** Our policy requires payment of co-payments, co-insurance, and any deductibles at the time of service. If there is any patient balance owed after all insurance companies have made their payments, we will bill you for that amount. All insurance information must be given to the office *prior* to your appointment or you could be responsible for the entire amount of the office visit and/or procedures. Any unpaid past due balances may be turned over to a collection agency.

**Patient Responsibilities:** 1) I understand that my insurance coverage is based on a legal contract between me and my insurance company. 2) I understand that I (as "Patient") am responsible for understanding and reading the conditions, coverage, terms, and limitations of my insurance policy. 3) I understand that the legal contract of my insurance policy requires me to be responsible for payment of valid and legitimate fees and charges as follows: All outstanding deductibles, co-payments, non-covered procedures and services that are performed, and outstanding valid charges and fees after insurance companies have made their payments and we have made contractual adjustments.

**HMO and PPO Members:** If you are a member of an HMO or PPO in which we participate, your co-payments, co-insurance, or deductible is required at the time of service. You are also responsible to see that we have a current referral on hand if your insurance carrier requires one. If we do not have this referral at the time of your visit, your appointment will be rescheduled. *Obtaining referrals and OV authorizations for **ANY** insurance company is the sole responsibility of **THE PATIENT**.*

**Cancellation Policy:** You must speak with someone in the office within 24 hours of the appointment if you are cancelling or rescheduling. If you fail to do so or if you do not come for the appointment, you will be expected to pay a $100 no-show fee in order to reschedule the surgery. All other appointments will be charged a $50 no-show fee.

_____ _____

Patient Name (printed) DOB

_____ _____

Patient Signature Date

**(OVER)** Form Update 11/8/23



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**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, **Tarantola Dermatology, Inc.** may use and disclose my protected health information **(PHI)** to carry out Treatment, Payment, and Healthcare Operations **(TPO)**. Please refer to Tarantola Dermatology Inc**. NOTICE OF PRIVACY PRACTICES** for 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. Tarantola Dermatology Inc. (the practice) reserves the right to revise the Notice of Privacy Practices at any time. A revised copy may be obtained from the Tarantola Dermatology Inc. Practice Manager.

With my consent, the above-mentioned doctor and staff may call my home or other designated location and leave a message on voice mail regarding any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items, account balances, and any call pertaining to my healthcare.

☐ Yes ☐ No

With my consent, the Practice may mail or email to my home or other designated location/s any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and other healthcare information including electronic prescriptions to designated pharmacies.

☐ Yes ☐ No

I have the right to request the Practice restrict how it uses or discloses my PHI; however, the Practice is not required to agree to my requested restrictions.

**By signing this form, I am consenting to Tarantola Dermatology Inc. and staff using and disclosing my PROTECTED HEALTH INFORMATION to carry out TPO. I may revoke my consent in writing except to the extent that the Practice has already made disclosures per my prior consent. This consent remains valid until revoked in writing by me.**

If I do not sign this consent, I may be declined treatment.

**Please allow the following person(s) to obtain my personal healthcare information. (If none, please write NONE)**

_____ _____
Name Relationship

_____ _____
Name Relationship

**Do you have a Medical Power of Attorney? This is someone who makes medical decisions for you.**

☐ Yes ☐ No

If YES, Name _____ . Bring these legal documents with you. We need to view them before evaluation and treatment can be provided.

_____ _____
Signature of Patient OR Legal Guardian Date

_____ _____
Printed Name DOB

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