Brighton Dermatology and Regenesis
6888 Grand River Ave., Brighton, MI 48114 (810) 220-4422

MRN#_____

Patient Information

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Race: ☐*White* ☐*Black or African American* ☐*Asian* ☐*American Indian / Alaskan Native* ☐*Native Hawaiian / Other Pacific Islander*

☐*Other* _____ ☐*Declined*

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Primary? ☐ Cell Phone: (_____)_____ Primary? ☐

Email Address: _____

Marital Status: S M W D Spouse's Name: _____ Spouse's Date of Birth: _____

How did you hear about our office? _____

Military History

☐YES ☐NO Years of service _____

Level of Education Completed

☐K-12 ☐Some College ☐College Degree ☐Other _____

Employer Information

Employer: _____ Employer Phone: (_____)_____ Occupation: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____ Phone: (_____)_____

Primary Care Physician

Name: _____ Address: _____ Phone: (_____)_____

Privacy Practices (HIPAA)

I have had the opportunity to review the Notice of Privacy Practices of Brighton Dermatology and Regenesis. (This document is available at our front desk.)

Patient Name (please print): _____ Signature: _____

Date: _____ Relationship to patient (if signed by a personal representative of patient): _____

If you are 18 or OLDER, we are unable to discuss your medical condition with other individuals in your family without your permission. Do you give us permission to discuss your confidential medical information with someone other than yourself? ☐ YES ☐ NO

IF YES, Name of person: _____ Phone Number: (_____) _____ Relationship to you: _____

(It is your responsibility to notify our office of any changes concerning your approved contact person.)

If patient is a minor (under the age of 18), please complete the following:

Father or Guardian	**Mother or Guardian**
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Phone Number: (_____)_____	Phone Number: (_____)_____

Unaccompanied Minors (under 18 Years Old): I understand that Brighton Dermatology and Regenesis is unable to treat unaccompanied minors unless prior consent is obtained from parent or legal guardian. A parental permission form is available upon request at our front desk. Non-emergency treatment will be denied unless we have this consent. New patient minors must have a parent or legal guardian present for the new patient exam.

I understand that I must make arrangements for payment of co-pay or other fees as needed at the time of service.

Signature of Parent or Guardian: _____ Date: _____

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FINANCIAL POLICY NOTICE and ACKNOWLEDGEMENT OF OFFICE POLICIES

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service. We accept cash, checks, MasterCard, Visa, Discover, American Express, and Care Credit. Please ask our staff about applying for Care Credit if you are interested.

Policy Benefits / Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Brighton Dermatology and Regenesis of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Services rendered may be considered non-covered by insurance and/or may be subject to a deductible in addition to a co-pay. I understand I have the right to refuse any services before they are rendered if I think they are non-covered services or not payable by my insurance.
We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnoses, co-pays, cost-shares, or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company. We accept cash, checks, MasterCard, Visa, Discover, American Express and Care Credit. Please ask our staff about applying for Care Credit if you are interested.

Out-of-Network Insurance Plans: I understand that full payment is required if I choose to be seen using an out-of-network insurance plan.

In-Network Insurance Plans: I understand I must provide a copy of my current insurance card in order to file an insurance claim. If I don't have my insurance card, and my benefits can not be verified, full payment may be due at the time of service. I authorize the release of my medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and I understand and agree to this financial policy. I request that my medical insurance carrier make any payment to Brighton Dermatology and Regenesis for services rendered to me.

Co-Payments: I understand that all co-pays are due at the time of my appointment. Due to the fact that Brighton Dermatology and Regenesis physicians are specialists, a higher co-pay may be required.

Managed Care (HMO) Plans: I understand it is my responsibility to obtain any and all referrals including referrals for follow up visits if my plan requires one. We will strive to keep you informed of how many visits are remaining on a referral and/or the expiration date, but it is ultimately the responsibility of the patient to know this information and to make the necessary arrangements through their primary care physician. If you do not have a current referral on file, you may be asked to reschedule your appointment.

Returned Checks: I understand that personal checks returned for non-sufficient funds may be charged a fee of $40. Balances must be handled by cash, credit card, or money order.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter is mailed. Please contact us before this if you would like to set up payment arrangements.

Medicare Insurance: I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand that if "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes the releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, insurance co-pay and non-covered services. Insurance co-pay and the deductible are based upon the charge determination of the Medicare Carrier.
I understand that Medicare does not make payment for patients who are incarcerated or in custody at the time of service.

Cancellation Policy: I understand if I cannot adhere to a scheduled appointment, it is my responsibility to call the office to cancel my appointment. Please note: Brighton Dermatology and Regenesis reserves the right to charge a $100 fee for filler appointments not cancelled within 24 hours, $50 fee for excision appointments (including Mohs surgery) not cancelled within 48 hours, and there will be a $250 cancellation deposit for varicose vein surgeries.

Consent to Treatment: I consent to the performance of diagnostic procedures, examinations, and rendering treatment by the medical provider and their designated medical office staff as it is deemed necessary in the medical provider's judgment.

PCMH: Brighton Dermatology and Regenesis is a participant in the **P**atient **C**entered **M**edical **H**ome (PCMH) network of the Livingston Physician Organization (LPO).

Pathology (biopsy) Results: Pathology (biopsy) results that are not discussed in person will be posted on your patient portal.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

_____ **Date:** _____

Signature of Patient or Guardian

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Past Medical History

Patient Name: _____

Please select any of the following medical conditions that you currently have.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Benign Prostatic Hypertrophy)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Gastroesophageal Reflux Disease)
- ☐ Other: _____
- ☐ Hearing Loss
- ☐ History of Hepatitis (check all that apply) A☐ B☐ C☐
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism (High Thyroid)
- ☐ Hypothyroidism (Low Thyroid)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Breast Reduction
- ☐ Breast: Implants
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Replacement
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA (Percutaneous Transluminal Coronary Angioplasty)
- ☐ Joint Replacement: Hip (Both)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Right)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR (Abdominoperineal Resection)
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: BCC (Basal Cell Carcinoma)
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: SCC (Squamous Cell Carcinoma)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Skin Disease History

Have you had any of the following conditions?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburn
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other: _____
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Patient has had NONE of these

Do you wear sunscreen? ☐Yes ☐No What SPF? _____ Do you tan in a tanning salon? ☐Yes ☐No

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Family History

Do you have a family history of **Melanoma** Skin Cancer? ☐Yes ☐No If you have a family history of Melanoma, which relative?

☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son ☐Unknown ☐Other: _____

Medications

Please list any medications you are currently taking. (Include Birth Control and Vitamins)

Medication: _____ Dosage: _____ Frequency: _____ Oral, Topical, or Injection? _____

Medication: _____ Dosage: _____ Frequency: _____ Oral, Topical, or Injection? _____

Medication: _____ Dosage: _____ Frequency: _____ Oral, Topical, or Injection? _____

Medication: _____ Dosage: _____ Frequency: _____ Oral, Topical, or Injection? _____

Medication: _____ Dosage: _____ Frequency: _____ Oral, Topical, or Injection? _____

Do you have any allergies to medication? ☐Yes ☐No If yes, please list:

_____

Social History

Smoking Status:

☐Current, every day smoker ☐Current some day smoker (tobacco) ☐Current some day smoker (cigarette)

☐Former smoker ☐Never smoker ☐Smoker, current status unknown

☐Unknown if ever smoked ☐Heavy tobacco smoker ☐Light tobacco smoker

When did you **start** smoking? _____ When did you **quit** smoking? _____

How many packs per day? _____ Total years smoking? _____

Social History Details

☐Not sexually active ☐Sexually active with one partner ☐Sexually active with more than one partner

☐Same sex partner ☐Drug use ☐IV Drug Use ☐Other: _____

Alcohol History

☐Patient does not drink alcohol ☐Less than one alcohol drink per day ☐1-2 alcoholic drinks per day ☐3 or more alcoholic drinks per day

Please answer the following questions by checking Yes or No.

Have you ever felt you needed to cut down on your drinking? ☐Yes ☐No
Have people annoyed you by criticizing your drinking? ☐Yes ☐No
Have you ever felt guilty about drinking? ☐Yes ☐No
Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hang over? ☐Yes ☐No

Additional History

Patient feels safe at home? ☐Yes ☐No

Have you had a flu shot? ☐Yes ☐No If yes, when was the date? _____

Have you had a pneumonia vaccine? ☐Yes ☐No If yes, when was the date? _____

Have you ever had any of the following: (If yes, please explain)

Reactions or allergies to local anesthetics such as those used by a dentist? ☐Yes ☐No _____

Bleeding disorders, frequent nosebleeds, easy bruising or bleeding longer than most people when cut? ☐Yes ☐No _____

Do cuts on your skin heal with normal scars? ☐Yes ☐No _____

Do you have any bleeding or non-bleeding lesions? ☐Yes ☐No _____

Have you ever fainted? ☐Yes ☐No _____

Have you had previous cosmetic surgery? ☐Yes ☐No _____