Patient Registration

Carlos Paz, MD, PhD
Melissa Manriques, FNP-C
Gabriel Zapata, PA-C
Clarissa Alvarado, FNP-C
Ines Nevarez, FNP-C

PATIENT INFORMATION:			
Name (Last, First, MI):	☐Jr. ☐Sr.		
Date of Birth: / /	Sex: ☐M ☐ F ☐ Married ☐ Divorced ☐Single ☐Widowed		
Address:			
City:	State: Zip:		
Email Address:			
	Can we email you appointment reminders? ☐Yes ☐No		
Cell Phone:			
	Can we text you appointment reminders? ☐Yes ☐No		
Home Phone:			
Patient's Social Security Number:			
Primary Care Physician (PCP) and Address:			
How did you hear about our office?	☐Doctor ☐Insurance Plan ☐Google ☐Yelp ☐Family/Friend ☐Other, specify:		
Primary Insurance:	Insurance Company Name:		
Subscriber Name:			
Subscriber's Date of Birth (Required)			
Subscriber's Social Security Number:			
Subscriber ID:	Group #: Policy #:		
Employer Name and Address:			
Patient's relationship to subscriber:	☐Self ☐Spouse ☐Child ☐Other If under 18, mother/father's name:		
Emergency Contact:	Name: Relationship to Patient: Phone Number:		
Please identify and provide phone number for any individual(s) with whom our staff can discuss your medical condition or bills.			
1.		☐Medical Information	☐Billing Information
2.		☐Medical Information	☐Billing Information
PHARMACY			
Pharmacy Name and Address:			
Pharmacy Phone Number:			
TREATMENT CONSENT			
I hereby give consent for medical treatment to the providers with PAZ Dermatology Specialists to care for myself or I am duly authorized by the patient as his/her agent or guardian to give consent for such treatment.			
Patient Signature (or signature by parent or guardian if patient is a minor) Date			

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Dermatology Medical History		
Reason for today's visit (chief complaint):		
How long have you had this problem?		
What parts of your body are affected?		
How does this problem bother you (symptoms)?		
What treatments have you received for this problem?		
Is your problem?	☐Worsening ☐Stable ☐Improving	
Cosmetic Consultation: Our office offers a variety of cosmetic services including Botox, fillers, laser treatments, liposuction, and cosmetic surgery. Are you interested in learning more about these services during your office visit? ☐Yes ☐No		
Women: Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No	Do you plan to become pregnant soon? ☐Yes ☐No	
Alerts: (Check All that apply)		
☐Allergy to lidocaine	☐Artificial joints (past 2 years)	☐Pacemaker
☐Artificial topical antibiotic ointments	☐Allergy to heart valve	☐MRSA
☐Premedication prior to procedures	☐Blood thinners	☐None
Any allergy to any other medication not listed above?	☐Yes ☐No	If yes, please list:
PAST MEDICAL HISTORY		
☐Anxiety ☐Arthritis ☐Asthma ☐Atrial fibrillation ☐Bone Marrow Transplantation ☐BPH (Benign Prostatic Hyperplasia) ☐Breast Cancer ☐Colon Cancer ☐COPD (Emphysema) ☐Coronary Artery Disease ☐Depression	☐Diabetes ☐End Stage Renal Disease ☐GERD (Acid reflux) ☐Hearing Loss ☐Hepatitis ☐HIV/AIDS ☐Hypercholesterolemia ☐Hypertension ☐Hyperthyroidism ☐Hypothyroidism	☐Leukemia ☐Lung Cancer ☐Lymphoma ☐Pacemaker ☐Prostate Cancer ☐Radiation Treatment ☐Seizures ☐Stroke ☐None ☐Other:
List all medications you are currently taking (including prescriptions, over-the-counter meds, etc.)		
1.	2.	3.
4.	5.	6.
PAST SURGICAL HISTORY		
☐Appendix Removed ☐Basal Cell Carcinoma Surgery ☐Breast Biopsy ☐Breast Implants ☐Coronary Artery Bypass ☐Gallbladder Removed ☐Hysterectomy: Fibroids ☐Hysterectomy: Uterine Cancer	☐Joint Replacement *(within last 2 years)* ☐Kidney Biopsy ☐Kidney Transplant ☐Lumpectomy ☐☐Left ☐Mastectomy ☐☐Left ☐Melanoma Surgery ☐Prostate Biopsy	☐Prostate Removed: Prostate Cancer ☐Skin Biopsy ☐Spleen Removed ☐Squamous Cell Carcinoma Surgery ☐None ☐Other, specify:
SKIN DISEASE HISTORY: (Check all that apply)		
☐Abnormal Moles ☐Actinic Keratoses ☐Acne	☐Eczema ☐Flaking or Itchy Scalp ☐Hayfever/Allergies	☐Psoriasis ☐Squamous Cell Carcinoma ☐None

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☐Basal Cell Skin Carcinoma	☐Melanoma	☐Other, specify:
☐Blistering Sunburns	☐Poison Ivy	
Do you wear sunscreen?	☐Yes ☐No	If yes, what SPF?
Do you tan in tanning salon?	☐Yes ☐No	
Do you have a family history of Melanoma?	☐Yes ☐No	If yes, which relative(s)?
Any other skin cancer family history?	☐Yes ☐No	Specify:

SOCIAL HISTORY: (Check all that apply)

Cigarette Smoking: ☐Never smoked ☐Quit: former smoker ☐Smokes less than daily ☐Smokes daily *Please note: If you are a smoker CMS requires us to encourage you to stop smoking. ☐ Initial	Do you drink alcohol? ☐Yes ☐No	How often do you exercise? ☐Once a day ☐A few times a week ☐Occasionally ☐Never
What is your caffeine use?	☐Once a day ☐A few times a week ☐A few times a month ☐Never	
Language: ☐English ☐Spanish ☐Other:	Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latin	Race: ☐White ☐Black/African American ☐American or Native Alaskan ☐Native Hawaiian/Pacific Islander ☐Asian

If needed, please elaborate on any of the above:

FINANCIAL AND BILLING POLICIES

I have read, understand, and agree to the financial billing policies (separate document provided). I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are patient responsibility.

Signature Date

NOTICE OF PRIVACY PRACTICES

I have read, understand, and agree to the Notice of Privacy Practices (separate document provided). It is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy on our website and you may request a printed copy of the revised Notice of Privacy Practice from our office when applicable.

Signature Date

CONSENT TO PHOTOGRAPH

This form is to be used only for photographs taken for treatment for PAZ Dermatology's own healthcare operations, as allowed under the federal privacy laws. Photography for other purposes (e.g., research, publication, outside education, marketing, public relations, news, or documentary) requires use of a separate form "consent to photograph and authorization for use and disclosure."

The undersigned hereby consents to be photographed while receiving treatment at the office, with the understanding that the images from such photography may be used for the patient's treatment or for the office healthcare operations, such as medical review, peer review, or medical education review, as the treating healthcare provider(s) deem appropriate. The term "photograph" as used herein includes video or still photography in digital or any other format, and any other means or recording or reproduction images.

Signature Date

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