Patient Registration Form

Welcome to the office of Dr. Adebola Dele-Michael, MD

Patient Information

Last Name	First Name	Middle Initial
Street Address	City/State/zip code	Social Security #
Phone number/other	Date of Birth	Male or Female
Cell Phone	Email	Marital status
Emergency contact & phone #	Pharmacy name and phone #	

Employer Information:

Name	Work Number	Occupation
Address	City/State/Zip Code	

Referred By: (From whom did you hear about the Doctor? Self referred, another Doctor, ZocDoc, other?)

Referred by:	Address	Phone #
Primary Care Physician:	Address	Phone #

Insurance Information:

Name of First Insurance Company	
Insurance ID Number	Local/Group Number
Name of Secondary Insurance Company	
Insurance ID Number	Local/ Group Number

Subscriber Information: (Policyholder if different from patient)

Relationship to Patient	Name	Date of Birth
Social Security Number	Address	City/ State/Zip Code
Phone Number	Employer's Name	Work Number

We will request to photocopy your insurance card(s) and photo ID of your file

Health History

Reason for Today's visit:

MEDICATION ALLERGIES: _____

Cigarette smoking:

PAST MEDICAL HISTORY: (Please check all that apply)

☐ None	☐ Colon Cancer	☐ Hypertension	☐ Radiation treatment
☐ Anxiety	☐ COPD	☐ HIV/AIDS	☐ Seizures
☐ Arthritis	☐ Coronary artery disease	☐ High cholesterol	☐ Stroke
☐ Artificial joints	☐ Depression	☐ Hypothyroidism	☐ Valve replacement
☐ Asthma	☐ Diabetes	☐ Leukemia	
☐ Atrial fibrillation	☐ End stage Renal disease	☐ Lung cancer	
☐ Benign prostate enlargement	☐ GERD	☐ Lymphoma	
☐ Bone Marrow Transplant	☐ Hearing loss	☐ Pacemaker	
☐ Breast Cancer	☐ Hepatitis	☐ Prostate cancer	
Other:			

PAST SURGICAL HISTORY

☐ None	☐ Breast reduction	☐ Heart valve replacement	☐ Prostate removed
☐ Appendix removed	☐ Breast implant	☐ Heart transplant	☐ Prostate biopsy
☐ Bladder removed	☐ Colon removed	☐ Joint replacement with last 2 years	☐ TURP
☐ Lumpectomy	☐ Gall bladder removed	☐ Kidney stone removal	☐ Mastectomy
☐ Breast biopsy	☐ Coronary artery bypass	☐ Kidney transplant	
Other:			

SKIN DISEASE HISTORY: (please check all that apply)

☐ None	☐ Dry Skin	☐ Posion ivy
☐ Acne	☐ Eczema	☐ Precancerous mole
☐ Actinic keratosis	☐ Flaky, itchy scalp	☐ Psoriasis
☐ Basal Cell cancer	☐ Seasonal allergies	☐ Squamous cell cancer
☐ Blistering sunburns	☐ Melanoma	Other:

Do you wear sunscreens?	If Yes, spf
Do you have a family history of melanoma?	If Yes, Which relative
Any other family history?	

MEDICATIONS: (please list all your current medications)

Financial Agreement

We are committed to providing you outstanding care and we are pleased to discuss our professional fees with you prior to being evaluated. Your clear understanding of our Financial Policy is important to our professional relationship.

APPOINTMENTS – 24 hours notice time must be provided by contacting the office to avoid a late cancellation fee of $150

REFERRALS – it is your responsibility to obtain a referral prior to your visit if your insurance requires it

CO-PAYMENTS – By law we must collect your carrier designated co-pay. This payment is expected at the time of service.

UNMET DEDUCTIBLE and CO-INSURANCE- Unmet deductibles and co-insurance corresponding to your visit's insurance allowed amount are due at the time of service.

OVERPAYMENTS: Overpayments are processed for refund after receipt of payment by your insurance.

OUT OF NETWORK PLANS – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible. **Should you receive payment from your insurance carrier, by signing below, you agree to forward the payment to our office.**

Private Insurance Authorization for Assignment of Benefits/Information Release:I, the undersigned, authorize payment of medical benefits to Radiant Skin Dermatology and Laser, PLLC for any services furnished. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. **Should I receive payment from my insurance carrier, I agree to forward the payment to the Doctor's office.**

SELF-PAY PATIENTS – Payment is expected at the time of service.

MEDICARE – The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Radiant Skin Dermatology and Laser, PLLC for any services furnished to me.

CHILDREN AND MINORS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Radiant Skin Dermatology and Laser, PLLC will not be involved with separation or divorce disputes.

COLLECTIONS: Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for 35% collections fee.

RETURNED CHECK POLICY: The charge for a returned electronic payment (ACH Payment) or a returned check is $20.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD. You will be charged. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share your concerns with us.

Patient's Name: **DOB:**

Responsible Party Signature: **Date:**

Print Name: **Relationship:**