



# Registration - Phoebe Rich Dermatology

Phoebe Rich, MD Jill Moore, MD Dr. Anna Hare Amy Simpson, PA-C

## Patient Information

First, Middle, Last Name Preferred Name and Pronouns Date of Birth Today's date

Address City, State, Zip Code

Home Number  Best to reach Cell Number  Best to reach Work Number  Best to reach

E-mail address  I would like to be web-enabled and receive results, see chart notes and schedule appointments online.

Name of Family Physician Phone Number

It is ok to share medical records between my medical providers when possible.

Marital Status:  Single  Married  Divorced  Widowed  Partner  
Sex:  Male  Female  Transgender  \_\_\_\_\_  
Employment Status:  Employed  Part-time Student  Full-time Student  Retired

*Please complete the following for children under 18 years of age:*

Parent/Guardian name Phone number Parent/Guardian name Phone number

RACE:  \_\_\_\_\_ ETHNICITY:  \_\_\_\_\_ PREFERRED LANGUAGE:  Decline to answer  Decline to answer  English  Other \_\_\_\_\_

## How were you referred to our office?

By a Doctor  By a Patient Please print the name of your source below.

## Employment Information

Employer Address City, State, Zip

## Person to Contact in Case of Emergency

Name Phone Number Relationship

Address (optional) City, State, Zip (optional)

## How Would You Prefer to be Contacted with Procedure Results?

Telephone (is it okay to leave a message? \_\_\_\_\_ )  
 Online through the Patient Portal (If you checked the web-enable box above you will be notified via the portal)

List persons we may leave messages with or discuss medical conditions with:

\_\_\_\_\_

## Pharmacy Information

Preferred pharmacy: \_\_\_\_\_ Phone Number if Available: \_\_\_\_\_

**Caretaker Information (If Applicable)**

_____		_____	_____
Name		Date of Birth	Relationship to Patient
_____		_____	
Address		City, State, Zip Code	
_____	_____	_____	
Phone Number	Cell Number	Occupation	
_____		_____	
Employer		Employer Phone Number	

**Insurance Information (if your insurance card was scanned in you can skip this section)**

_____		_____	_____
Name of Policy Holder		Date of Birth	Relationship to Patient
_____		_____	_____
Insurance Company		Group Number	ID Number
_____		_____	
Address		City, State, Zip Code	

**Consent to Treatment**

Permission is given to Phoebe Rich, MD and staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition. We will be happy to discuss your concerns at any time. During your visit your health and safety are our main concern. We usually recommend a full skin examination for patients who are new to our office to search for and document benign and potentially malignant skin lesions. You can opt out of a full skin examination if you wish, but we recommend it at least once a year, especially if you have had a previous skin cancer. If a suspicious appearing or concerning skin lesion is discovered, a biopsy or surgical excision may be recommended. As with all medical and surgical procedures there are risks of scarring, infection at the surgical site, bleeding, allergic reaction to anesthesia, acute or chronic pain, and slow healing, especially on lower extremities and feet. We always do our best to minimize side effects and scarring, but scars and keloids can occur, and are more likely with removal of large skin cancers on the upper torso and face, even under the best surgical conditions. We want you to ask any and all questions that you may have regarding your skin treatment and surgical procedures, especially about the risks and alternative treatments that may be available, and we hope you will not hesitate to inquire. Our goal is to provide the very best care possible for your skin conditions, and to work together with you as a team and assure your skin health.

**Financial Responsibility and Assignment of Benefits**

**I am** supplying Phoebe Rich Dermatology with insurance information. I authorize my insurance company to pay directly to Phoebe Rich Dermatology all benefits due for my medical care, and hereby consider this an assignment of benefits. I authorize Phoebe Rich Dermatology to provide all information my insurance company requests concerning my treatment. If my insurance company requires a referral from my primary care physician and I did not obtain a referral prior to my appointment, I am financially responsible for all services. It is understood that I am financially responsible for all services not covered or allowed by my insurance company, including out of office services such as pathology services and lab testing (also including deductibles and co-pays). Any money received in excess of my charges will be refunded when my bill is paid in full. I understand that if I do not show up for an appointment, or if I cancel with less than 24 hours notice, I will be charged a \$50 fee.

**-OR-**

I am **not** supplying Phoebe Rich Dermatology with insurance information. I understand that I am financially responsible for all services performed. I understand and will comply with the financial policy of Phoebe Rich Dermatology.

_____	_____
<i>Patient or Other Legally Authorized Person</i>	<i>Date</i>