

Grafton Dermatology.

DISEASES OF THE SKIN, HAIR AND NAILS.



microdermabrasion

medical facials

tattoo removal

laser resurfacing

laser hair removal

spider veins

body sculpting

skin cancer removal

HOUMA

MORGAN CITY

THIBODAUX

MEDICARE PATIENT REGISTRATION FORM

Date _____

Name of Patient: _____ Male or Female

Address: _____
Street State Zip

Date of Birth ___/___/___ Age _____ Home Phone _____

Social Security Number ___/___/___ Married Single Widowed—Please Circle One

Referred By _____

In case of an emergency, who should we notify: _____

Primary Care Physician _____ Phone Number _____

Medicare ID # _____

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to the payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature Date

Do you have a Supplement Insurance Policy? Yes No

If Yes, Name of Supplement Insurance: _____

Policy Number: _____

Is the Supplement Insurance under your spouse name? Yes No

If yes, Spouse Name: _____ Date of Birth: _____

I request authorized Supplement Insurance Benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above insurance carrier any information needed to determine these benefits or the benefits payable for related services.

Patient Signature Date

Please present your insurance cards and photo ID to the receptionist.
The receptionist will make a copy and return them to you promptly.

Thank you for choosing our office to assist you in caring for your skin.

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MEDICAL HISTORY

Date _____

Name of Patient: _____ Date of Birth ___/___/___

Reason for visit _____

Are you allergic to any medication? No Yes "if yes, list:"

List medications you are currently taking:

Do you have or have ever had diseases or conditions of: (Please check YES or NO)

Lungs	Yes	No	Other Systemic	Yes	No
Bronchitis	Yes	No	Diabetes	Yes	No
Emphysema	Yes	No	Thyroid	Yes	No
Asthma	Yes	No	Kidney	Yes	No
Chronic Cough	Yes	No	Bladder	Yes	No
Morning Cough	Yes	No	Stomach	Yes	No

Vascular

High Blood Pressure	Yes	No
Chest Pain	Yes	No
Heart Attack	Yes	No
Heart Murmur	Yes	No
Irregular Heart Beat	Yes	No
Pace Maker	Yes	No
Phlebitis	Yes	No

Bowel

Hepatitis	Yes	No
Glaucoma	Yes	No
Arthritis	Yes	No
Convulsions	Yes	No
Epilepsy	Yes	No
Seizures	Yes	No
Fainting	Yes	No

Do you drink alcohol No Yes "If yes, drinks per day _____"

Do you use IV drugs No Yes "If yes, what _____"

Have you had or have you ever been exposed to HIV (AIDS) No Yes

Have you ever had dental anesthesia (Novacaine) No Yes

Any bad reaction? No Yes

Skin

"When you are exposed to the sun, do you?"	Tan	Tan and burn	Burn
Have you ever had skin cancer?	No	Yes	
Has any one in your family had skin cancer?	No	Yes	
Do you have a history of any skin diseases?	No	Yes	

"If yes, Please list: _____"

List any other disease or condition we should know about: _____

List any surgeries you have had: _____

Please answer the following questions:

Do you smoke? No Yes "If yes, how much _____"

Do you bleed easily? No Yes

(Women) Are you pregnant? No Yes Due Date: _____

Do you have artificial joint(s)? No Yes

What is your occupation _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits, for which I am entitled.

I will not hold Grafton Dermatology responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Date _____

Name of Patient: _____

Date of Birth __/__/__

Please list below a person or persons (other than your self) to whom we can disclose your medical information:

When calling your home, can we leave a message for you? Yes No

Can we call a cell phone number? Yes No

If yes, Please give the number _____

Can we call your place of employment? Yes No

If Yes, Please give phone number _____

Would you like our office to call and remind you of any future appointments? Yes No

Please list any special contact instructions:

Patient Signature

Date

If you need further assistance please call our office at 985.876.5000 or email us at info@graftonderm.com.