MILLIGAN DERMATOLOGY

REGISTRATION FORM

35-200 Bob Hope Drive
Rancho Mirage CA, 92270
Phone (760) 328-8884 Fax (760)202-3931

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home phone #:	Cell phone #:		Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	

Email Address:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home #: ( )	Cell Phone # ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient Signature: _____ Date:_____

This document will be scanned for computer recall. Please PRINT with LARGE BOLD LETTERS.

DERMATOLOGY QUESTIONNAIRE

Name_____ **Telephone #**_____ **Date** _____
Date of Birth_____ **Height**_____ **Weight**_____
Reason for visit: (Circle all that apply) **Acne:** Past prescriptions:_____ **Removal of lesion:** (Location?)_____ **Rash:** (Duration?)_____ **Skin Exam:** Anything in particular that is bothersome?_____
Allergies to Medications:_____
CIRCLE which one applies to you: Non-Smoker Former Smoker Smoker (How Long?)_____
Have you recently been discharged from a hospital?(Circle) YES NO
Do you have an Advanced Care Plan? YES NO
Have you had the pneumonia vaccine? YES NO
Prescription Medication List: _____
_____
_____
Do YOU have a history of skin cancer?_____
Medical or Chronic Diseases:_____
Past Major Surgeries:_____
Do you have diabetes?_____ **How long?**_____
Have you had a history of cancer?_____ **Type?**_____
Family History of: Skin Cancer_____ **Melanoma**_____**Diabetes**_____

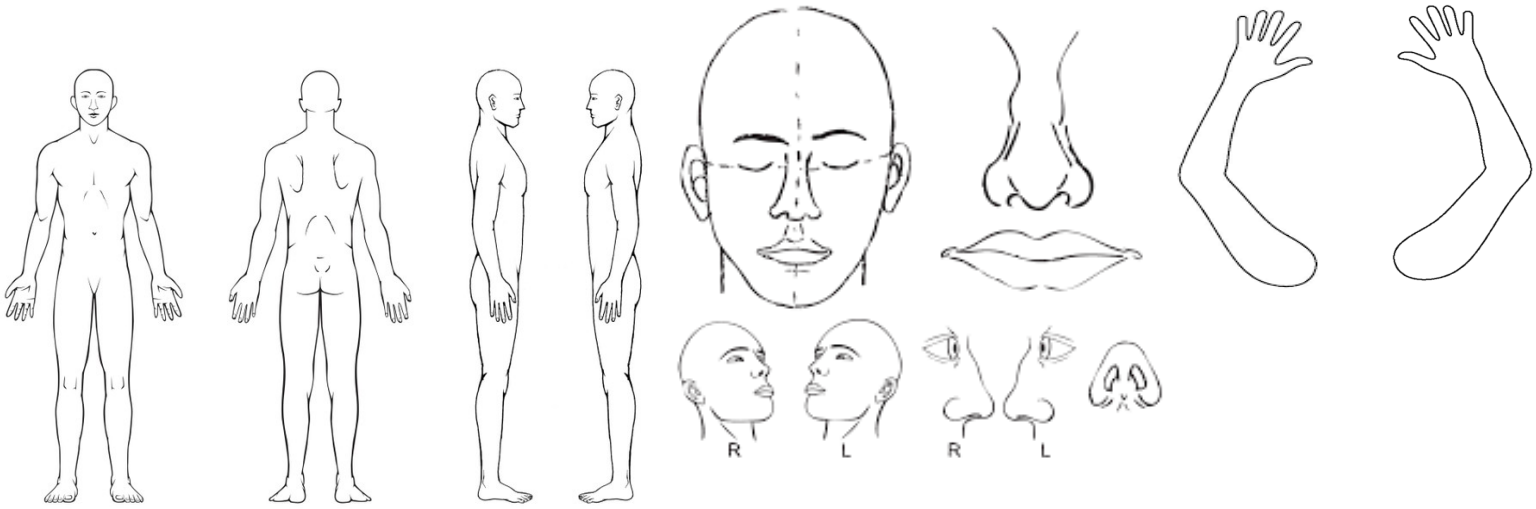
CIRCLE: In excellent general health **OR CIRCLE** if you have, or have had any of the following:

Pre-Cancers l Skin Cancer l Psoriasis l Eczema l Hives l Asthma l Pregnancy l Hay Fever l Heart Disease l Rheumatoid Arthritis l Kidney Disease l Liver Disease l Hepatitis l HIV l Ulcers l Psychiatric l Hypertension l Glaucoma

You may desire removal of non-cancerous skin growths such as small keratosis, tags, or moles. These may be easily removed with mild pain, short healing time, and excellent cosmetic improvement. Dermatological surgery of larger skin lesions may also be desired. Recurrence, persistent discoloration, and scarring may occur but are rarely a problem. Scarring is inevitable, but is almost always cosmetically acceptable and often imperceptible. Risks of bleeding, infection, persistent pain rarely occur but are possible. Cosmetic treatments such as the removal of wrinkles or spider veins are not billable to insurance. I have received the office Privacy Policy in accordance with federal guidelines.

Patient or Guardian Signature_____

FOR OFFICE USE ONLY - PLEASE DO <u>NOT</u> WRITE BELOW THIS LINE



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MICHAEL P. MILLIGAN, M.D.
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(760)328-8884 (760)202-3931

PRIVACY POLICY

The Federal Government has passed new laws designed to protect the privacy of your medical records. The laws mandate that each patient receives a written Privacy Policy from each medical provider and also sign a consent form to allow parts of his/her medical record to be shared, when appropriate, with other physicians, insurance and governmental agencies. Below are my privacy policies and consent form to be signed.

1. Patients records will not be shared with anyone other than treating physicians without patient consent.
2. Any information from the patient's records shared with an insurance company or governmental agency will only be with the patient's consent and will contain only the minimum amount of information necessary for billing, obtaining new insurance or legal purposes.
3. You as a patient may inspect or get copies for your records at any time with a written request and a 3-day notice.
4. Legal procedures, such as subpoenas for your records, will be observed in accordance with the law.
5. Transmission of information regarding HIV test results will be in accordance with the law and will not be made to individuals without your written consent.

CONSENT FORM

1. I agree that if as a part of my treatment my doctor needs to share my records in whole or part with another physician, it is permitted.
2. I agree to share a minimum amount of information from my record to my insurance company so that billing can be processed appropriately.
3. I agree that as a part of their office duties, office staff will have access to my medical records. I understand that they are not permitted to share any information in that record with those outside the office.