Patient Information: **Blair S. Kranson M.D. Patient Registration Form**

Referred By:_____

Last Name:_____ First Name:_____ MI:_____

Sex:_____ DOB:____/____/_____ Place of Birth (City and State)_____/_____

Social Security Number: _____-_____-_____ Martial Status (circle one): S | M | D | W

Language: _____ Race:_____Occupation:_____

Contact Information:

Address:_____

Address Apt City State Zip code

Home Phone: (___)_____

Cell Phone: (___)_____

Work Phone: (___)_____

Preferred Contact Method (circle one):
Home | Work | Cell | Email

Is it okay to leave a detailed message (circle one): Yes | NO

Email Address: _____

Insurance Information (Skip if a copy of insurance card is available):

Primary Insurance Carrier: _____ Phone: (____)_____

Policyholder (Name on Card): _____

ID#: _____ Group#: _____

If you are **NOT** the policyholder, what is your relationship to the policyholder? _____

Policyholder's Date of Birth: ____/__/_____ Policyholder's SSN#: _____-_____-_____

Pharmacy Information:

Pharmacy Name: _____ Phone Number: (____)_____

Address:_____

Address City State Zip Code

Emergency Contact:

Name:_____ Relationship:_____

Phone number: (____)_____

Guarantor: (Fill out only if patient is a minor)

Parent/Legal Guardian Name:_____DOB: ____/____/_____

Phone Number (Cell or Home): (___)_____ SSN #: ____/__/_____

Address (If different from Patient):_____

Address City State Zip-code

Assignment of Rights & Benefits

I hereby assign all rights and benefits under my contract with my insurance company to Blair Kranson M.D. a professional corporation, for the purposes of determining the details of the benefits of my policy and obtaining payment for services given.

The assignment further permits Dr. Kranson to obtain from my insurance all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Dr. Kranson of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered. The assignment shall allow Dr. Kranson to take all actions necessary to obtain the benefits I have, in good faith, been promised by my insurance. All benefits are to be paid directly to Dr. Kranson. A photocopy of this assignment shall be considered as effective and valid as the original. I further authorize Dr. Kranson to initiate a complaint to the Insurance Commissioner's Office for any reason on my behalf.

I understand that my insurance carrier may disallow certain diagnoses or services medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to me or my dependents. I also understand that my insurance policy is a contract between my insurance company and I. If my insurance company does not pay my claim within 30 Days after it is received, I agree to remit payment to Dr. Kranson within 2 weeks of receiving the bill and contact my insurance company regarding this settlement. Dr. Kranson and his staff will assist me in processing my claim: however, I'm ultimately responsible for payment of my account.

Policy Holder/Insured _____

Print Patient Name Patient Signature Date

Patient Responsibility for Late cancellation of Appointment:

I understand that it is my responsibility to inform the office no later than **24 hours** prior to my scheduled follow up appointment and **1 week** prior to my scheduled procedure if I am unable to keep the appointment. If I cancel my appointment AFTER the 24 hour/1 week time period or "NO SHOW". I understand that I will be charged a fee according to the length of time allotted for my appointment. Regular office visits will be charged a $25 fee. Procedure appointments will be charged a $50 fee. Mohs Micrographic Surgery (Skin Cancer) will be charged $200 due to the cost of the lab technician that is paid on per case basis. If I have any questions regarding these fees, I will ask for further explanation.

I have read and understand the cancellation policy _____

Patient Signature Date

Biopsy/Surgery Second Opinion Pathology:

I have been notified that **if necessary**, my biopsy/excision may be sent out for a second opinion to a dermatopathologist (a pathologist that specializes in diseases/growths of the skin) and I agree to be personally and fully responsible for payment. Due to insurance company policy, which is outside of our control, second opinions are billed individually and on the day of reading and not the day of the physician visit and may be subject to separate co-pays.

I have read and understand the policy _____

Patient Signature Date

Past Medical History: (please circle all that apply)

None
Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/ AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other:_____

Past Surgical History: (please circle all that apply)

None
Appendix Removal
Bladder
Breast Biopsy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colostomy
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Mechanical Valve Replacement
PTCA
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Biopsy
Joint Replacement within last 2 years
Spleen (Splenectomy)
Uterus (Hysterectomy): Fibroids
Kidney Stone Removal
Kidney Transplant
Kidney Removal (Right, Left)
Liver: Hepatectomy
Liver: Transplant
Liver: Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate Biopsy
Prostate: Prostatectomy
Prostate: TURP
Rectum: APR
Rectum: Low Ametrias Resection
Skin Biopsy
Melanoma/Basal/Squamous Surgery
Testicles
Uterus (Hysterectomy): Uterine / Cervical Cancer
Other:_____

Reason for Visit:
What brings you to the office?_____

_____

Skin Disease History: (please circle all that apply)

None
Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin
Other:_____

Do you tan in a tanning salon? Yes No
Do you wear sunscreen? Yes No
Do you have family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications (Name Dosage/Frequency):

1._____ 2._____ 3._____ 4._____
5._____ 6._____ 7._____ 8._____

Allergies:

1._____ 2._____ 3._____ 4._____

Social History Details (circle one)

Have you ever smoked? Yes | No Do you smoke now? Yes | No
How much alcohol do you drink per week? (# of drinks) _____
How much caffeine do you drink per day? (#of drinks) _____
How often do you exercise? _____

Women Only:

Are you pregnant? (circle one) Yes | No Are you breast feeding? (circle one) Yes | NO

Family History (circle that apply)

Abnormal Moles
Acne
Allergies
Arthritis
Asthma
Basal Cell Carcinoma
Cancer
Diabetes
Eczema
Melanoma
Psoriasis
Skin Cancer
Squamous Cell Carcinoma
Details:_____
_____

Review of Systems (circle that apply)

Hematologic/Lymphatic
Problem with Bleeding

Integumentary
Problems with healing
Problems with scarring
Rash

Allergic/Immunologic
Immunosuppression
Hay Fever

Cardiovascular
Chest Pain

Constitutional/symptom
Fever or Chills
Night sweats
Unintentional weight lost

Endocrine
Thyroid problems

ENT and Mouth
Sore throat

Eyes
Blurry Vision

Gastrointestinal
Abdominal Pain
Bloody Stool

Genitourinary
Bloody Urine

Musculoskeletal
Joint Aches
Muscle weakness
Neck Stiffness

Neurological
Headaches
Seizures

Respiratory
Cough
Shortness of breath
Wheezing

Psychiatric
Anxiety
Depression

Alerts (circle that apply)

Allergy to Adhesive
Allergy to Lidocaine
Allergy to topical antibiotic ointments
Artificial heart valve
Rapid Heart Beat with epinephrine
Blood thinners
Immunosuppression
Problem with Healing
Artificial Joints requiring premedication
MRSA
Pacemaker
Premedication prior to procedures
Allergic reaction to Neosporin/ Ointments
Pregnancy or planning a pregnancy
Problem with Bleeding
Defibrillator

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature_____ Date_____