ZALADONIS
DERMATOLOGY
ASSOCIATES

1665 Valley Center Parkway, Suite 120 | Bethlehem, PA 18017 | 610.868.3150

REGISTRATION

(PLEASE PRINT)

Date _____ Home Phone/Cell Phone _____

Patient _____
Last Name First Name Initial

Email Address _____

Street Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____

Occupation _____ Business Phone _____

Spouse Name _____ Birthdate _____

Business Name _____

Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Do you have Medical Insurance? ☐ No ☐ Yes ► If yes,

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

Family Physician _____ Referring Physician _____

In case of emergency, who should be notified? _____ Phone _____

How did you learn of our practice? _____

PAYMENT REQUESTED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Zaladonis Dermatology Associates for services rendered by providers in person or under supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Zaladonis Dermatology Associates to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE - MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT _____ DATE _____

To be completed by patient - please print

HISTORY AND INTAKE FORM

All information is strictly confidential

Name _____ DOB _____

PAST MEDICAL HISTORY *(check all that apply)*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colitis
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None
- ☐ Other _____

PAST SURGICAL HISTORY *(check all that apply)*

- ☐ Basal Cell Cancer Surgery
- ☐ Biological Valve Replacement
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Coronary Artery Bypass
- ☐ Gallbladder Removed
- ☐ Heart Transplant
- ☐ Hysterectomy
- ☐ Mastectomy ☐ Right ☐ Left ☐ Bilateral
- ☐ Lumpectomy ☐ Right ☐ Left ☐ Bilateral
- ☐ Joint Replacement, Hip ☐ Right ☐ Left ☐ Bilateral
- ☐ Joint Replacement, Knee ☐ Right ☐ Left ☐ Bilateral
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Removed ☐ Right ☐ Left)
- ☐ Kidney Transplant
- ☐ Mechanical Valve Replacement
- ☐ Melanoma Surgery
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ PTCA
- ☐ Skin Biopsy
- ☐ Spleen Removed
- ☐ Squamous Cell Carcinoma Surgery
- ☐ TURP
- ☐ None
- ☐ Other _____

SKIN DISEASE HISTORY *(check all that apply)*

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ 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 Cancer
- ☐ None
- ☐ Other_____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF: _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma: ☐ Yes ☐ No

If yes, which relative(s)? _____

Any other family history: _____

HISTORY AND INTAKE FORM *(cont.)*

Name _____ DOB _____

MEDICATIONS: (Please enter all current medications)

_____

_____

_____

_____

ALLERGIES: (Please enter all allergies)

_____

_____

_____

_____

SOCIAL HISTORY *(check all that apply)*

CIGARETTE SMOKING:

☐ Never Smoked

☐ Quit: former smoker

☐ Smokes less than daily

☐ Smokes daily

RACE:

☐ White

☐ Black/African American

☐ Asian

☐ American Indian or Native Alaskan

☐ Native Hawaiian/Pacific Islander

ETHNICITY:

☐ Hispanic/Latino

☐ Non-Hispanic/Latino

LANGUAGE:

☐ English

☐ Spanish

PHARMACY:

Name: _____

Address _____

_____

Phone: _____

REASON FOR VISIT _____

_____

_____

_____

_____

_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Zaladonis Dermatology Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Zaladonis Dermatology Associates' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Zaladonis Dermatology Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy of Practices may be obtained by forwarding a written request to Zaladonis Dermatology Associates, Privacy Officer at 1665 Valley Center Parkway, Suite 120, Bethlehem, PA 18017.

With my consent, Zaladonis Dermatology Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Zaladonis Dermatology Associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Zaladonis Dermatology Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Zaladonis Dermatology Associates use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Zaladonis Dermatology Associates may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I,_____, have received a copy of Zaladonis Dermatology Associates' Notice of Privacy Practices.

_____ _____
Signature of Patient Date

ZALADONIS
DERMATOLOGY
ASSOCIATES

DERMATOLOGY AND DERMATOLOGIC SURGERY

Joseph J. Zaladonis, Jr., MD | Mary E. Hutchins, MD | Veronica L. Rutt, DO

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY

FELLOW AMERICAN ACADEMY OF DERMATOLOGY

HIPAA RELEASE OF INFORMATION

NAME: _____ DOB: _____

☐ I authorize the release of information including the diagnosis, medical examination, and claims information rendered to me. This information may be released to and/or my primary care physician:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

☐ I do not want my information released to anyone other than myself and/or my primary care physician.

PHONE MESSAGES

Please call: Home:_____ Work: _____

Cell: _____ Email: _____

The information provided above may be used by our office staff and an automated reminder call system.

This policy shall remain in effect until terminated by me in writing.

Signature:_____ Date: _____

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Signature of Patient Date