

BLUEGRASS DERMATOLOGY
Patient Registration Form

Date: _____

Chart Number: _____

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ Address: _____ Apt. / Suite: _____

City/State/Zip: _____ Social Security Number: _____

E-mail Address: _____ (REQUIRED FOR PATIENT PORTAL ACCESS)

Home Phone: (____) _____ Cell Phone: (____) _____ Birth Date: _____

How would you like to receive appointment reminders? Phone call Text E-mail All Three

Race: Caucasian African American Hispanic / Latino Asian American Indian Other _____

Ethnicity: Hispanic Non-Hispanic Gender: Female Male Marital Status: Single Married Divorced Widowed

Primary Language: _____

Primary Care Provider (Per Medicare and most insurances, you are required to list a primary care provider [PCP])

Name: _____ City/State/Zip: _____ Phone: (____) _____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____

City/State/Zip: _____ Phone: (____) _____

Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____

Employer: _____ Address: _____

City/State/Zip: _____ Work Phone: (____) _____

RESPONSIBLE PARTY BILLING INFORMATION Relationship to Patient: Self Parent Guardian POA Other _____

Name: _____ Birth date: _____ Address: _____

City/State/Zip: _____ Social Security Number: _____

PRIMARY INSURANCE

Insurance Name: _____ I.D. #: _____

Group #: _____ Effective Date: _____

Subscriber Name: _____ Relationship to Patient: _____

SECONDARY INSURANCE

Insurance Name: _____ I.D. #: _____

Group #: _____ Effective Date: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company, including, but not limited to co-pays, deductibles and co-insurance payments.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan with which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of CASH, CHECK, VISA, DISCOVER, AMERICAN EXPRESS, MASTERCARD, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS. We also participate with Care Credit Financing. All balances due that do not get paid within the first 30 days are subject to finances which will accrue interest monthly.

PATIENT Signature (or Parent/Guardian or POA): _____ Date: _____

BLUEGRASS DERMATOLOGY
Patient Medical History Form

Patient Name: _____ Birth Date: _____ Chart Number: _____

MEDICAL HISTORY (circle all that apply) [] I do not have any medical history problems and/or conditions

Anxiety	Hepatitis	Seizures
Asthma	High Blood Pressure	Stroke
Bleeding Problems	HIV / AIDS	Thyroid Disorders
Blood Clots	Inflammatory Bowel Disease	Tuberculosis
Cancer _____	Kidney Disease	Tumors _____
Depression	Liver Disease	
Heart Disease	Migraines/Headaches	

SURGICAL HISTORY (circle all that apply) [] I do not have any past surgical history

Skin Cancers _____	Heart / Lung Surgery _____
_____	Joint Surgery _____
_____	Liver / Kidney Surgery _____
Skin Biopsy _____	Prostate or Testicular _____
Brain or Spine Surgery _____	Stomach/Intestine/Colon _____
Breast or Gynecological _____	Other Cancer Surgery _____

SKIN MEDICAL HISTORY (circle all that apply) [] I do not have any skin medical history problems and/or conditions

Basal Cell Carcinoma	Actinic Keratoses	Flaky or Itchy Scalp
Melanoma	Allergies	Poison Ivy
Skin Cancer (unknown type)	Atypical or abnormal moles	Psoriasis
Squamous Cell Carcinoma	Blistering Sunburns	Skin Infections
Acne	Eczema	Tanning Bed Use

SOCIAL HISTORY (Please answer ALL of the following questions)

[] Never smoker and/or tobacco user [] Former smoker and/or tobacco user [] Current smoker and/or tobacco user
[] I do not drink alcohol [] I drink alcohol **Current alcohol users:** [] < 1 drink per day [] 1-2 drinks per day [] ≥ 3 drinks per day
How many times in the past year have you had ≥ 5 drinks in a day for men, or ≥ 4 drinks in a day for women _____
[] I have had flu vaccine current / past flu season [] I have not had flu vaccine [] I do not take flu vaccine [] I am allergic to the flu vaccine
[] I have had pneumonia vaccine [] I have not had pneumonia vaccine [] I do not take pneumonia vaccine [] I am allergic to the pneumonia vaccine

Surrogate Decision Maker (i.e. Living Will, POA, or family member / friend who can help you in medical emergencies)

[] I have a surrogate decision maker [] I do not have a surrogate decision maker [] I have a living will [] I have a POA
If you have a surrogate decision maker, who is it? _____ Phone: (_____) _____

FAMILY HISTORY (circle all that apply) [] I do not have a family history of any medical conditions

Please do not include yourself and/or spouse and only list family member(s) who had the medical condition

Melanoma (family member _____)	Cancer (family member _____)
Other Skin Cancers [unknown type] (family member _____)	Diabetes (family member _____)
Other Pertinent Family History _____	Eczema or Psoriasis (family member _____)

Patient Signature (or Parent/Guardian or POA): _____ Date: _____

BLUEGRASS DERMATOLOGY
Patient Review of Systems Questionnaire Form

Are you currently experiencing any of the following? (Please mark Yes or No for the following):

SYMPTOMS

- | | | |
|---------------------------|-----------------------------|------------------------------|
| Abdominal Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blurry Vision | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Chapped Lips | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Depression | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Dry Skin | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Joint Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Swollen Lymph Nodes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Fever and Chills | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cough | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Nausea or Vomiting | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Unintentional Weight Loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

SYMPTOMS

- | | | |
|--------------------------------|-----------------------------|------------------------------|
| Rash | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Problems with Bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Problems with Scarring/Healing | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Changing Mole | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Thyroid Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Sore Throat | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Muscle Weakness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Night Sweats | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Seizures | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heartburn | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Wheezing | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Please mark Yes or No for the following:

- Do you take a blood thinning medication? Common blood thinning medications are: Aspirin, Brilinta (Tricagrelor), Coumadin (Warfarin), Plavix, Pradaxa, Xarelto, Imbruvica (Ibrutinib) No Yes
- Do you have an artificial heart valve? No Yes
- Do you require antibiotics prior to a surgical procedure? No Yes
- Do you have a defibrillator and/or pacemaker? No Yes
- Have you had an artificial joint replacement within the past two (2) years? If yes, when and what body locations? _____ No Yes
- Have you been diagnosed as having human immunodeficiency virus (HIV)? No Yes
- Have you been diagnosed as having Hepatitis B or C? No Yes

FEMALE PATIENTS PLEASE ANSWER THE FOLLOWING QUESTIONS:

- Are you trying to become pregnant? N/A No Yes Maybe
- Are you currently pregnant? N/A No Yes Maybe
- Are you currently nursing? N/A No Yes
- If you are of child-bearing potential, are you using contraception? N/A No Yes
 If yes, what contraception are you currently using? _____

Patient Signature (or Parent/Guardian or POA): _____ Date: _____



Bluegrass Dermatology

Skin Surgery Center, P.S.C.

3475 Richmond Rd. Suite 200

Lexington, KY 40509

(859)296-4400

Fax (859)296-4300

Driving Directions to the Office

Hours of Operation:

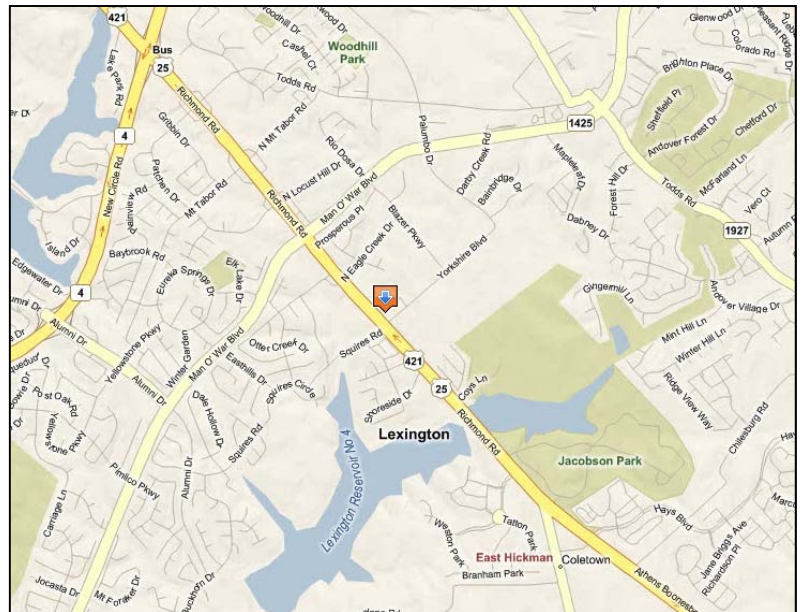
Monday – Thursday: 8 am – 6 pm

Friday: 8 am – 5 pm

Closed: Weekends and Major Holidays

Coming From Interstate 75 South:

1. At exit 104, take ramp right for KY-418 toward Lexington / Athens.
2. Turn left onto SR-418 / Athens Boonesboro Rd
3. Road name changes to US-25 North / US-421 North / Richmond Rd.
4. Turn right onto Yorkshire Blvd, our parking lot is the first drive to your left.



Coming From Interstate 75 North:

1. Take the Man O'War Blvd exit #108 – KY-1425W.
2. Stay straight on Man O'War Blvd and turn left onto Pumbo Drive.
3. Stay straight on Pumbo Dr, there will be a sharp turn to the right and the road name changes to Yorkshire Blvd.
4. Stay on Yorkshire Blvd to the end. Our parking lot is the last drive on your right.

Coming from New Circle Road:

1. Take the US-25S./US-421S. exit #15 towards Richmond / Interstate 75.
2. Stay on Richmond Rd heading towards Interstate 75.
3. After crossing Man O'War Blvd, turn left at the 2nd traffic light, onto Yorkshire Blvd.
4. Our parking lot is the first drive to your left.

Coming from the Bert T. Combs Mountain Parkway:

1. Take the Mountain parkway to Interstate 64 W.
2. Merge onto I-75 S. via exit 81 on the left towards Richmond / Knoxville.
3. Take the Man O'War Blvd exit#108 – KY-1425W.
4. Stay straight on Man O'War Blvd and turn left onto Pumbo Drive.
5. Stay straight on Pumbo Dr, there will be a sharp turn to the right and the road name changes to Yorkshire Blvd.
6. Stay on Yorkshire Blvd to the end. Our parking lot is the last drive on your right.