BLUEGRASS DERMATOLOGY
Patient Registration Form

Date: _____ **Chart Number:** _____

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ Social Security Number: _____ Birth Date: _____

Address: _____ Apt. / Suite: _____ City/State/Zip: _____

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

Home Phone: (_____)_____ Cell Phone: (_____)_____

Preferred Number: [ ]Home [ ]Cell Can we leave a detailed Message: [ ]Yes [ ] No Method for 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: _____

Employer: _____ Address: _____

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

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

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

Name: _____ Birth date: _____ Address: _____

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

INSURANCE INFORMATION

Please double check your insurance card to see if a referral is required by your PCP (your PCP's name will be printed on the front of your card or you may see "referral required") in order to be seen by a specialist. If so, the referral authorization must be received by our practice PRIOR to your appointment. Insurance plans will NOT accept a referral request by our office.

Primary: _____ I.D. #: _____

Group #: _____ Effective Date: _____ Subscriber Birth Date: _____

Subscriber Name: _____ Gender: _____ Relationship to Patient: _____

Secondary: _____ I.D. #: _____

Group #: _____ Effective Date: _____ Subscriber Birth Date: _____

Subscriber Name: _____ Gender: _____ Relationship to Patient: _____

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.

PHARMACY AND PRIMARY CARE PROVIDER (Per Medicare and most insurances, you are required to list a primary care provider [PCP])

Pharmacy Name: _____ Address: _____

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

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

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

BLUEGRASS DERMATOLOGY
Patient Medical History Form

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

Were you referred here by another physician for a specific issue? ___Yes ___No

If Yes: Physician's name:_____ Phone Number: _____

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

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

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

Skin Cancers _____
_____
_____
Skin Biopsy _____
Brain or Spine Surgery _____
Breast or Gynecological _____
Heart / Lung Surgery _____
Joint Surgery _____
Liver / Kidney Surgery _____
Prostate or Testicular _____
Stomach/Intestine/Colon _____
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
Melanoma
Skin Cancer (unknown type)
Squamous Cell Carcinoma
Acne
Actinic Keratoses
Allergies
Atypical or abnormal moles
Blistering Sunburns
Eczema
Flaky or Itchy Scalp
Poison Ivy
Psoriasis
Skin Infections
Tanning Bed Use

MEDICATION INFORMATION [ ] I am not currently taking any medications

(List all medication you are currently taking and include all over-the-counter medications, herbals, vitamins, and minerals)
It is important you fill in ALL of the fields for each medication

Medication(s) Name (What is the name of the medication?)	**Strength Unit** (Strength of medication)	**Route** (How you take it? ie oral, injection, under tongue, etc)	**Dose** (How many taken?)	**Dose Form** (ie tablet, capsule,liquid, gel, etc)	**Frequency** (How often is medication taken?)	**Indication** (What medical condition does it treat?

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

BLUEGRASS DERMATOLOGY
Patient Medication/Allergy History Form

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

Medication(s) Name (What is the name of the medication?)	**Strength Unit** (Strength of medication)	**Route** (How you take it? ie oral, injection, under tongue, etc)	**Dose** (How many taken?)	**Dose Form** (ie tablet, capsule,liquid, gel, etc)	**Frequency** (How often is medication taken?)	**Indication** (What medical condition does it treat?

ALLERGY INFORMATION [ ] I do not have any allergies to any medications

Medication	**Allergic Reaction**

Do you have an allergy to Latex Products? □ No □ Yes

Do you have an allergy to Adhesives? □ No □ Yes

Do you have an allergy to Lidocaine? □ No □ Yes

Do you have an allergy to Topical Antibiotic Ointments? □ No □ Yes

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

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

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			SYMPTOMS		
Abdominal Pain	□ No	□ Yes	Rash	□ No	□ Yes
Blurry Vision	□ No	□ Yes	Problems with Bleeding	□ No	□ Yes
Chapped Lips	□ No	□ Yes	Problems with Scarring/Healing	□ No	□ Yes
Depression	□ No	□ Yes	Changing Mole	□ No	□ Yes
Dry Skin	□ No	□ Yes	Thyroid Problems	□ No	□ Yes
Headaches	□ No	□ Yes	Sore Throat	□ No	□ Yes
Joint Pain	□ No	□ Yes	Muscle Weakness	□ No	□ Yes
Swollen Lymph Nodes	□ No	□ Yes	Night Sweats	□ No	□ Yes
Fever and Chills	□ No	□ Yes	Seizures	□ No	□ Yes
Cough	□ No	□ Yes	Heartburn	□ No	□ Yes
Nausea or Vomiting	□ No	□ Yes	Wheezing	□ No	□ Yes
Unintentional Weight Loss	□ No	□ 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:

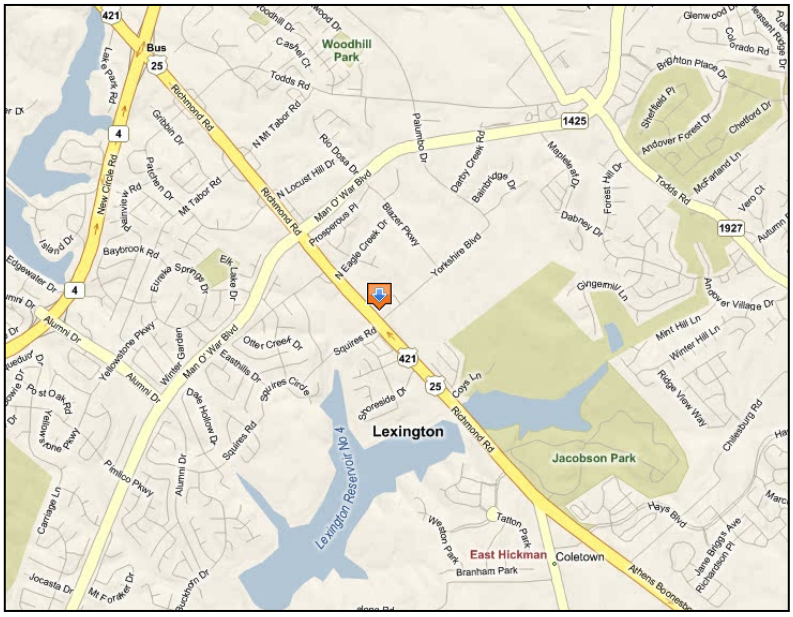
- Are you trying to become pregnant? □ N/A □ No □ Yes □ Maybe

- 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:** _____

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 Polumbo Drive.
3. Stay straight on Polumbo 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 Polumbo Drive.
5. Stay straight on Polumbo 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.