BLUEGRASS DERMATOLOGY
Patient Registration Form

(Form updated 6/1/2026)

Date: _____ **Chart Number:** _____

PATIENT DEMOGRAPHIC INFORMATION:

Legal Name: _____ Preferred 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 Telephone 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 Ethnicity: [ ] Hispanic [ ] Non-Hispanic
[ ] Asian [ ] American Indian [ ] Other _____

Gender Identity: [ ] Male [ ] Female [ ] Trans Male [ ] Trans Female [ ] Androgynous [ ] Other Pronoun: _____

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: _____

PRIMARY CARE PROVIDER INFORMATION:

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

Primary Care Provider's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____

BLUEGRASS DERMATOLOGY

Pharmacy and Insurance Information

PHARMACY INFORMATION: (Please list below the primary pharmacy you would like your medications electronically sent to. Our office will not give you a printed paper prescription for any medications. All medications will be sent electronically.)

Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____

PRESCRIPTION BENEFITS INFORMATION:

If you have prescription benefits, please fill in the required information below. This information is usually included on your medical insurance card. Some medications that your provider would prescribe to use requires the office to include this information in a prior authorization for you to receive the mediation(s). If any of this information is not filled in, it runs the risk of your medication(s) being delayed.

ID # _____ Rx Plan: _____

Rx BIN Number: _____ Rx PCN: _____

Rx GROUP 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 copy 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.

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
Pacemaker
Seizures
Stroke
Thyroid Disorders
Tuberculosis
Tumors _____
Other _____
_____

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

Skin Cancers _____
Heart Surgery _____
Lung Surgery _____
Joint Surgery _____
Liver Surgery _____
Kidney Surgery _____
Skin Biopsy _____
Prostate or Testicular _____
Brain Surgery _____
Back Surgery _____
GI Surgery _____
Breast Surgery _____
Gynecological Surgery _____
Other 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?

BLUEGRASS DERMATOLOGY
Patient Medication/Allergy History Form

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

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 / Vaper User and/or Tobacco User [ ] Former Smoker / Vape User and/or Tobacco User
[ ] Current Smoker / Vape User and/or Tobacco User

Women over 65 Years of Age Only:
[ ] I have Urinary Incontinence. [ ] I DO NOT have Urinary Incontinence.

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 (family member _____)
Cancer (family member _____)
Diabetes (family member _____)
Eczema (family member _____)
Psoriasis (family member _____)
Other Pertinent Family History_____

BLUEGRASS DERMATOLOGY

Patient Review of Systems Questionnaire Form

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

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:** _____

Bluegrass Dermatology
HIPAA (Health Insurance Portability and Accountability Act) Consent Form

Patient Name: _____ Date of Birth_____ Chart #_____

As required by the **Health Insurance Portability and Accountability Act (HIPAA) of 1996**, this practice may use your health information for the purposes of treatment, payment, or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Information Practices by describing the restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

- 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.
- **Acknowledgement of Receipt of Privacy Practices:** I acknowledge the practice has a copy of the Notice of Privacy Practices which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information, and that I can obtain a copy per request.
- **Consent to Treat:** I hereby authorize examination and treatment by Bluegrass Dermatology. I authorize the release of any medical information necessary to process claims to insurance carriers (and/or the Social Security Administration/CMS or intermediaries). I permit a copy of this authorization to be used in place of the original. All information gathered will remain confidential by our HIPAA policy.

CONSENT: I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

- I understand that I may request restrictions on the uses and disclosure of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.
- I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to this practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.
- Is there anyone (i.e. spouse, parent, guardian or family member) you authorize us to share any medical information with, if you are not available? [ ] YES [ ] NO
    - If yes, please provide their name & contact information below:

      Name: _____ Relationship: _____

      Home Phone: _____ Cell Phone: _____

RESTRICTION REQUEST SECTION ***If you do NOT want the physicians or staff at Bluegrass Dermatology to leave test result; appointment; or billing/account information on your personal voicemail, please make note in the Restriction detail below.

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

_____

_____

* If you are over 18 years of age and under your parent's insurance policy, please check the box: [ ]

Signature of Responsible Party: _____ Date: _____

Bluegrass Dermatology Office Policies Consent Form

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

The following is a review of our office policies. Please review and sign below.

PAYMENT RESPONSIBILITY: The patient is responsible for all insurance deductibles, co-pays and coinsurance on the day of service (subject to plan limitation, and exclusions).

PAYMENT OPTIONS: We accept CASH, CHECK, VISA, DISCOVER, AMERICAN EXPRESS, MASTERCARD, CARECREDIT, MONEY ORDERS, and CASHIERS CHECKS. You can apply for CareCredit in our office today. All balances that are not paid within the first 90 days are subject to being transferred to an outside collection agency.

INSURANCE POLICIES THAT REQUIRE A REFERRAL FROM THE PCP: Some insurance plans require a referral from the patient's primary care provider (PCP). The PCP will need to initiate the referral by contacting the insurance company. It is the patient's responsibility to make sure this has been done prior to each appointment date. Otherwise, the patient is responsible for ALL charges.

NETWORK PROVIDERS: It is your responsibility to know if your physician is considered "in network" with your insurance policy. Some insurance companies change their policy administrator. We encourage you to confirm in network status with our office each time you receive a new copy of your insurance card or contact your insurance company.

MEDICAID NON-PARTICIPATION POLICY: Our physicians are not participating Medicaid providers and Medicaid does not cover services provided by our physicians. Similarly, Medicaid does not cover items or services ordered by our physicians such as, but not limited to, prescription medications, lab work, outside pathology services, diagnostic testing, etc***. Medicaid recipients are responsible for payment of services provided and/or ordered by our physicians***.

COSMETIC AND SELF-PAY SERVICES: Cosmetic removal of benign lesion(s) such as skin tags, age spots, and normal moles is considered a cosmetic procedure. Bluegrass Dermatology does not bill insurance companies for cosmetic procedures. The patient is responsible for the full cost of the procedure. ***All cosmetic and self- pay visits are due at check in on the date of service***.

TREATMENT FEES: Treatment fees are estimates only and could be altered if your treatment plan needs to be changed. The patient would be notified of any change(s) in treatment.

CANCELLATION FEE: A missed appointment fee of $200 will be assessed for surgical and laser appointments, and $50 for office visits that are cancelled with less than 48 hours' notice, or if you fail to show up for your appointment.

TREATMENT OF MINORS: Minors under the age of 18 will receive medical care and/or treatment with a parent, legal guardian, or an authorized accompanying adult only. Minors under 18, who are not accompanied, will not be seen.

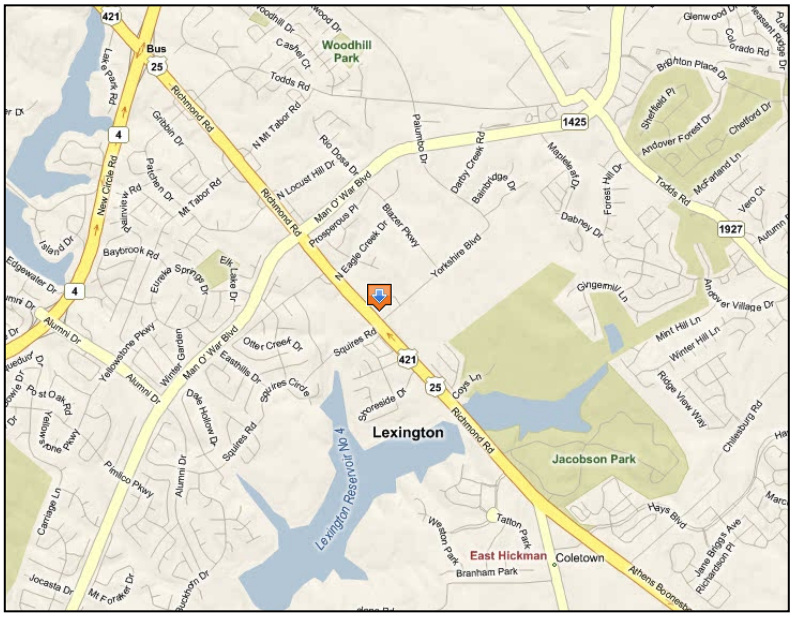
PRESCRIPTION REFILL POLICY: Our physicians prescribe sufficient refills for their patients until their next follow-up appointment; therefore, we are unable to refill prescriptions by telephone. Patients should contact their Pharmacy if refills are needed prior to their next follow-up appointment.

CONTROLLED SUBSTANCES: Bluegrass Dermatology occasionally will need to prescribe a controlled substance for patient's physical complaints/pain, as part of their medical treatment. Because of Kentucky's prescription drug law, we will submit patient information to obtain a report (Kentucky All Schedule Prescription Electronic Reporting (eKASPER) prior to prescribing any controlled substances to a patient.

LABORATORY FACILITIES: All surgical pathology and other lab specimens are submitted to outside laboratories for processing and analysis. The patient may receive a separate bill from the laboratory that processes and tests specimens. It is the patient's responsibility to let us know if your insurance company requires that we send your labs to a specific pathologist in order for you to receive full benefits.

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 the exit ramp 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 Palumbo Drive.
3. Stay straight on Palumbo 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 Palumbo Drive.

5. Stay straight on Palumbo 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.