Garrett R. Bohrnstedt, DO
119-A Tradewynd Drive
Lynchburg, Va 24502-5288
Phone: 434-237-3376 / Fax: 434-237-3330

Patient Registration Form

PATIENT INFORMATION **Referring Physician**_____

Patient Name: Last_____ First _____ Middle _____

Address _____ City_____ State _____ZIP _____

Sex: (Please Circle) Male/Female Marital Status _____ Title: (Please Circle) Dr. Mr. Mrs. Ms.

Birth date _____ - _____ - _____ Social Security # ____ ____ ____ - ____ ____ - ____ ____ _____

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

(Patient Portal Access) Email Address: _____

Employer/Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone Number (_____) _____

RESPONSIBLE PARTY

Guarantor's Name _____ Phone Number (_____) _____
Address _____City _____State_____ ZIP _____
(If different from above)
Patient Relation to Guarantor _____ Guarantor Employer _____
Employer Address: _____ City _____ State _____ ZIP _____
Guarantor SS# ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Guarantor Birth date _____

PRIMARY
Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

SECONDARY
Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

I hereby authorize Seven Hills Dermatology to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Seven Hills Dermatology benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's signature (or responsible party) _____ Date _____

Patient Name: _____

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Thyroid Problems
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial Fibrillation	End Stage Renal Disease	Lymphoma
Bone Marrow	GERD	Prostate Cancer
Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood Pressure	Stroke
COPD	HIV/Aids	
	High Cholesterol	**NONE**

Other: _____

_____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy (Nephrectomy)
Bladder Removed	Kidney Stone Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP (Prostate Removal)
Gallbladder Removed	Spleen Removed
Coronary Artery Bypass	Testicles Removed (Right, Left, Bilateral)
Mechanical Valve Replacement	Hysterectomy: Fibroids
Biological Valve Replacement	Hysterectomy: Uterine Cancer
Heart Transplant	
Joint Replacement, Knee (Right, Left, Bilateral) Year: _____	**NONE**
Joint Replacement, Hip (Right, Left, Bilateral) Year: _____	

Other: _____

Patient Name: _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/ Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	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)? _____

Do you have a family history of other skin cancers? Yes No
If yes, explain, (ex. Mother- basal cell carcinoma, squamous cell carcinoma)
_____

Medications: (Please enter all current medications)

_____
_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently smokes	EtOH- none
Never smoked	EtOH- 1-2 drinks per day
Former smoker	EtOH- 3 or more drinks per day
	EtOH- occasionally

Other: _____

Patient: _____

Do you have any of the following: (please circle all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement within last two years
Currently take blood thinners
Pacemaker
Defibrillator
History of MRSA
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant? Yes No

Other:

Preferred language: _____
Race: _____ Ethnic Group: _____

Preferred Pharmacy Name: _____
City and Zip Code of Pharmacy: _____

Collections Agreement:

Collection Agency/Attorney Fees: In the event that your account is turned over to a collection agency or attorney, you agree that you will be responsible for a collection fee equal to 33.3% of the outstanding balance due on the date the account is turned over for collection. Collection Costs: In the event that the account becomes delinquent and is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

Patient/Responsible Party signature: _____

Cancellation Policies:

Seven Hills Dermatology is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. To cancel a Monday appointment, please call our office by 11:00 am on the Friday prior to your appointment. If 24 hours of prior notification is not given, you will be charged $50.00 for the missed appointment. Because a surgery appointment can last for up to one hour in length, a last-minute cancellation can result in preventing up to 6 patients from being seen. If 24 hours of prior notification is not given for a surgery cancellation, you will be charged $100.00 for the missed appointment. Please call us at (434)-237-3376, 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. Please sign below to consent to these terms.

Patient/Responsible Party signature: _____

Laboratory Notice:

Please be advised that Seven Hills Dermatology utilizes DLCS (Dermpath Lab of Central States) for all of our laboratory needs. This lab may or may not be in-network with your insurance company. Seven Hills Dermatology does not have access to patient financial responsibility to DLCS, as it is a separate company. We believe that it is imperative to provide our patients with the highest level of expertise in the field of dermatology which is why we use a lab that only practices dermatopathology specifically. Thank you for allowing us to provide you with the best care available. Please sign below to consent to these terms.

Patient/Responsible Party signature: _____

Cosmetic Payment Notice:

Please note that all cosmetic service(s) are not covered by insurance companies (including Medicare & Medicaid). For Medicare & Medicaid patients, this means that cosmetic services will not be covered by any of your insurance payers and the service is determined to be medically unnecessary. If a cosmetic procedure is performed at your appointment; this means that you will incur all costs for the procedure (unrelated to the office visit) and you will be given notice of the cost prior to service. If you decide to proceed with the procedure, you will be financially responsible for all costs at the time of service. Please sign below to consent to these terms.

Patient/Responsible Party signature: _____

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. Authorization to Disclose PHI (Protected Health Information). I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. Persons to Whom Disclosure May be Made. Provider may disclose my PHI to the following persons:

Name	Relationship, if any
_____	_____
_____	_____
_____	_____

3. Purpose of Disclosure. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or know the status of my health.

4. Expiration of Authorization. This authorization shall continue until I revoke this authorization in writing, which I may do at any time be sending a letter addressed to the Privacy Office to any office where I am treated by Provider.

5. Conditioning of Treatment. Provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this consent.

6. Re-disclosure by Recipient. I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by federal or state law.

7. Acknowledgement of Reading and Agreement. I have read and understand this authorization.

_____ _____

Signed Patient Name or Representative **Date**

Relationship of Patient Representative to Patient _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

SEVEN HILLS DERMATOLOGY, LLC reserves the right to modify the privacy practices outlined in the notice.

I have read the copy of the Notice of Privacy Practices for SEVEN HILLS DERMATOLOGY, LLC.

Name of Patient: _____

Signature of Patient: _____

Date:_____

Signature of Patient Representative: _____
(Required if patient is a minor or an adult who is unable to sign form)