Dr. Yeoman's Dermatology Office P.C.

1-855-669-2482

PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL Sections below!
If unable to complete, one of our staff members will assist you.

Dr. Yeoman's Dermatology
1-855-669-2482 Office P.C.

Today's Date: _____

PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Name: _____
Last Name First Name Middle Initial Maiden Name

Street Address: _____ (Apt. # _____)

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cellphone/Pager: (____) _____ Email: _____

Date of Birth: ____ /____ /____ Social Security #: _____
Month Date Year

Do you wish correspondence to be confidential? ☐ Yes ☐ No May we contact you at work? ☐ Yes ☐ No

Reason for Visit: _____

REFERRAL INFORMATION

How did you hear of us? _____ ☐ Friend ☐ Doctor ☐ Other

Referring Doctor: _____ Phone: (____) _____

Primary Care Doctor (if different from referring): _____ Phone: (____) _____

EMERGENCY CONTACT

Name/Relationship: _____ Phone Number: _____

RESPONSIBLE PARTY INFORMATION

Complete if different from patient.

Responsible Party name: _____ Date of Birth: ____ /____ /____

Social Security # : ____ / ____ / _____ Relationship to patient: _____

ASSIGNMENT OF BENEFITS - FINAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lance Yeoman, D.O and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and any reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits or coordination of care.

I further agree that a photocopy of this agreement shall be as valid as the original.

Patient or Responsible Party Signature: _____ Date: _____

JOINT NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Joint Notice of Privacy Practice (NPP) is provided to all patients. This NPP identifies:

- How medical information about you may be used or disclosed;
- Your rights to access, amend medical information, request an accounting of disclosures, and request additional restrictions on our uses and disclosures of that information;
- Your right to complain if you believe your privacy rights have been violated; and
- Our responsibilities for maintaining the privacy of your medical information.

RELEASE OF INFORMATION

I authorize Dr. Yeoman's Dermatology Office, P.C. to release medical information about my treatment and care to:

Name/Relationship: _____ Phone Number: _____

Name/Relationship: _____ Phone Number: _____

Name/Relationship: _____ Phone Number: _____

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE I'VE READ THE "NOTICE OF PRIVACY PRACTICES".

Patient/ Guarantor's Signature: _____ Date: _____

Patient Name: _____ DOB: _____

OFFICE POLICIES

Our goal is to provide and maintain a quality physician-patient relationship. To assure you are fully informed in advance of your appointment, we are providing you with our office policies to achieve good communication which enables us to achieve our goal. ***Please read each section carefully and initial***. If you have any questions, do not hesitate to ask a member of our staff.

APPOINTMENTS

We value time we have set aside to see and treat you. If you are unable to keep an appointment, we require a 24-hour notice. There is a charge of $50 for a missed clinic appointment and $200 for a missed surgical appointment.

- If you are late for an appointment ,it may be necessary to reschedule your appointment.
- We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
- If you "No-Show" for 2 clinic/surgical appointments, you will be dismissed from the practice.

Initials_____

INSURANCE PLANS

- It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate Is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement
- It is your responsibility to understand your benefit plan:i.e., deductible, covered services and participating labs.
- It is your responsibility to know if a written referral or authorization is required to see a specialist, whether preauthorization is required prior to a procedure, and what services are covered.

Initials_____

FINANCIAL RESPONSIBILITY

- You are responsible for any and all co-pays, deductibles and coinsurances as applicable.
- Co-payments are due prior to seeing the provider. If you are unable to furnish your co-pay, you must reschedule your appointment.
- Self-pay patients (see separate policy)

POPLAR BLUFF OFFICE
225 Physicians Park Dr. • Suite 203 • 2nd Floor At The Coppertop • Poplar Bluff, Missouri • 63901
Phone: 573-686-4750 • Fax: 573-686-4753

PARAGOULD OFFICE
1707 Linwood Dr. • Suite B • Paragould, Arkansas • 72450
Phone: 870-215-0622 • Fax: 870-215-0611

thedermatologyoffice.com

• If we do not participate in your insurance plan, you can choose to pay for your visit in full and we will provide you with a receipt that you can submit to your insurance provider.
• Your patient balance will be billed on receipt of your insurance plan's explanation of benefits (EOB) and is due 10 business days upon your receipt.
• If previous arrangements have not been made with our office manager, any outstanding balances longer than 60 days will be turned over to our collection agency.
• We accept cash, checks, VISA, Mastercard Discover credit and debit cards.
• A $25 fee will be charged for any checks returned for insufficient funds.

Initials_____

TRANSFER OF RECORDS

• If you transfer to another physician, we will provide a copy of your record and your last visit to your physician free of charge as a courtesy to you. We need 48 hours advanced notice.
• A copy of your complete record is available for the usual and customary rate.

PRESCRIPTION REFILLS

• For monthly medication refills, we require a 48-hour notice during regular business hours.

I have read the above policies regarding my financial responsibility to Dr. Yeoman's Dermatology Office PC. for providing medical services to me or the patient listed below. I certify that the information is correct to the best of my knowledge, accurate and true. I authorize my insurance provider to pay any benefits directly to Dr." Yeoman's Dermatology Office PC., agree to comply and accept the responsibility for any balance that" becomes due as outlined previously .

Patient Name (s): _____

Responsible Party Member's Name: _____ Relationship _____

Responsible Party Member's Signature _____ Date _____

Employee Signature _____ Date _____

POPLAR BLUFF OFFICE
225 Physicians Park Dr. • Suite 203 • 2nd Floor At The Coppertop • Poplar Bluff, Missouri • 63901
Phone: 573-686-4750 • Fax: 573-686-4753

PARAGOULD OFFICE
1707 Linwood Dr. • Suite B • Paragould, Arkansas • 72450
Phone: 870-215-0622 • Fax: 870-215-0611

thedermatologyoffice.com

MEDICAL HISTORY FORM

Name: _____ DOB: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy Name: _____

PAST MEDICAL HISTORY

- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Stroke

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratoses (Pre-Cancerous Lesions)
- ☐ Basal Cell Skin Cancer
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking Or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer
- ☐ Do You Wear Sunscreen?(If yes, what SPF?)

  _____
- ☐ Do you tan in a tanning salon?
- ☐ Family HX of MELANOMA?(If yes, which relative?)

  _____

SOCIAL HISTORY

- ☐ Currently Smokes
  Packs per day --------
- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Drug Use
- ☐ IV Drug Use

MEDICATIONS

_____

_____

_____

ALLERGIES

_____

_____

_____

POPLAR BLUFF OFFICE
225 Physicians Park Dr. • Suite 203 • 2nd Floor At The Coppertop • Poplar Bluff, Missouri • 63901
Phone: 573-686-4750 • Fax: 573-686-4753

PARAGOULD OFFICE
1707 Linwood Dr. • Suite B • Paragould, Arkansas • 72450
Phone: 870-215-0622 • Fax: 870-215-0611

thedermatologyoffice.com

REASON FOR VISIT

Date of Birth: _____ Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

INTEGUMENTARY
- ☐ Picked Cotton
- ☐ Enlarged Lymph Nodes
- ☐ Open lesions
- ☐ Itching or Pruritis
- ☐ Do you have tattoos?

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Edema or Swelling

EYES
- ☐ Cataracts
- ☐ Dry Eyes
- ☐ Glasses/ Contacts
- ☐ Blurry Vision

GENITOURINARY (G.U)
- ☐ Painful Urination
- ☐ Bloody Urine

ENT & MOUTH
- ☐ Bleeding Gums
- ☐ Nose Bleeds
- ☐ Hard of Hearing
- ☐ Ear Pain

HEMATOLOGIC/ LYMPHATIC
- ☐ High Cholesterol

NEUROLOGICAL
- ☐ Headaches
- ☐ Abnormal balance
- ☐ Alert & Oriented
- ☐ Do you wear your seatbelt?
- Which is your dominant hand?
  - ☐ Left
  - ☐ Right

CONSTITUTIONAL/ SYMPTOM
- ☐ Happy
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Unintended Weight Loss
- ☐ Appetite Changes

ALERTS
- ☐ Allergy To Lidocaine
- ☐ Allergy to Adhesive
- ☐ Allergy To Topical Antibiotic
- ☐ Allergy to Latex
- ☐ Frequent Sun Exposure
- ☐ Problem with Healing
- ☐ Problem with Scarring
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Rapid Heart beat with Epinephrine
- ☐ Pregnancy or Planning Pregnancy
- ☐ Breast Feeding
- ☐ Breast Augmentation
- ☐ Breast Mastectomy
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Problems with Bleeding
- ☐ Blood Thinners
- ☐ Brulse Easily
- ☐ Confusion/ Dementia
- ☐ Seizures
- ☐ Fever or Chills Today
- ☐ Hallucinations

POPLAR BLUFF OFFICE
225 Physicians Park Dr. • Suite 203 • 2nd Floor At The Coppertop • Poplar Bluff, Missouri • 63901
Phone: 573-686-4750 • Fax: 573-686-4753

PARAGOULD OFFICE
1707 Linwood Dr. • Suite B • Paragould, Arkansas • 72450
Phone: 870-215-0622 • Fax: 870-215-0611

thedermatologyoffice.com

MEDICAL HISTORY FORM

OTHER

- ☐ Lumps in your Breast
- ☐ Recent Mammogram

MUSCULOSKELETAL

- ☐ Joint Aches
- ☐ Fibromyalgia
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Multiple Sclerosis

RESPIRARTORY

- ☐ Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ COPD
- ☐ Shortness or Breath
- ☐ On Oxygen
- ☐ Oxygen 24/7
- ☐ Oxygen at night

GASTROINTESTINAL (G.I.)

- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Recent Colonoscopy
- ☐ Constipation/ Diarrhea
- ☐ Irritable bowel syndrome (IBS)
- ☐ Acid Reflux
- ☐ Ulcers
- ☐ Crohn's Disease
- ☐ Hepatitus Acute
- ☐ Hepatitus Chronic
- ☐ Anxiety
- ☐ Depression
- ☐ Thyroid Problems