BURKE DERMATOLOGY

REGISTRATION FORM - PLEASE PRINT **Date: _____**

Patient Information

Mr.____ Mrs.____ Ms.____ Dr.____ **Email: _____**

_____

First Name **Middle Initial** **Last Name**

Address: _____ **Unit/Apt**: _____ **City:** _____ **State**: _____ **Zip Code:** _____

Phone [H] (_____) _____ **[W]** (_____) _____ **[C]** (_____) _____

Date of Birth: _____ **Age:** _____ **Social Security Number:** _____-_____-_____

Occupation: _____ **Employer:** _____

Check Appropriate Option: ____Single ____Married ____Widowed ____Divorced ____Other

Ethnicity: ____Hispanic or Latino ____ Not Hispanic or Latino ____Unknown

Race: ____ American Indian or Alaska Native ____ Asian ____ Black or African American ____ White

____Native Hawaiian ____ Other Race

Language: ____ English ____ Spanish ____ Other: _____

Primary Care MD: _____ **Primary Care MD Phone Number:** _____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Emergency Contact:_____ **Emergency Contact Phone Number:**_____

Spouse

COMPLETE IF INSURANCE IS THROUGH SPOUSE

Full Name: _____ **Address(if different from above):**_____

City:_____ **State:**_____ **Zip:**_____ **Date of Birth:** _____ **SS Number:**_____-_____-_____

Phone [H] (_____) _____ **[W]** (_____) _____ **[C]** (_____) _____

Occupation: _____ **Employer:** _____

Parents

Father's Name: _____ **Address** *(if different):* _____

City: _____ **State**: _____ **Zip Code:** _____ **Date of Birth:** _____ **SSN:** _____-_____-_____

Phone [H] (_____) _____ **[W]** (_____) _____ **[C]** (_____) _____

Mother's Name: _____ **Address** *(if different):* _____

City: _____ **State**: _____ **Zip Code:** _____ **Date of Birth:** _____ **SSN:** _____-_____-_____

Phone [H] (_____) _____ **[W]** (_____) _____ **[C]** (_____) _____

****Person financially responsible for patient's visit (please check): Father:** _____ **Mother:** _____

****Signature on File Statement****

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE BENEFITS, BE MADE TO EITHER ME OR ON MY BEHALF TO BURKE DERMATOLOGY FOR ANY SERVICES RENDERED TO ME BY THE PROVIDERS AT BURKE DERMATOLOGY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, OR OTHER FACILITIES, AND ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATIED SERVICES.

BECAUSE THE OFFICE SCHEDULES IN ADVANCE, WE ASK THAT YOU KINDLEY GIVE US A 24 HOUR NOTICE FOR ANY CANCELLATIONS. THIS WILL ALLOW US TO USE FILL YOUR APPOINTMEN TIME IF NECESSARY. WE MAY CHARGE FOR CONSECUTIVE MISSED APPOINTMENTS WITHOUT APPROPRIATE NOTICE OF 24 HOURS IN ADVANCE.

PLEASE SIGN BELOW INDICATING THAT YOU HAVE READ THE ABOVE INFORMATION:

Signature: _____ **Today's Date:** _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PATIENT PRIVACY AND RIGHTS DISCLOSURE

Burke Dermatology and its employees disclose information given to us by you, your insurance company, primary care doctor and/or other medical professionals strictly for the purpose of treatment, payment of services rendered or health operations. We do not sell mailing lists or disclose personal information about our patients expect that which is needed to carry out our objective, which is your health care. In compliance with HIPAA guidelines, the patient understands they have the right to add an addendum to such records if recorded information is disputed. By signing this consent, you agree to allow Burke Dermatology to use and disclose personal information about you for the reason above. You have the right to revoke this consent at any time but must be aware that we cannot guarantee your care unless we can communicate with other health care professionals when necessary. This notice of privacy will become part of your medical record.

Signature: _____ **Today's Date:** _____

If you would like to sign up for the billing portal and receive paperless statements (via text/email), please select below:

_____ **Yes** _____ **No, not currently.**

774 Christiana Rd.
Suite 107
Newark, DE 19713
Ph:302-230-3376
Fax:302-224-4990

212 Carter Dr.
Suite A
Middletown, DE 19709
Ph:302-449-2400
Fax:302-376-8676

95 Wolf Creek Blvd.
Suite 1
Dover, DE 19901
Ph: 302-734-3376
Fax:302-734-3379

1058 S. Governors Ave.
Suite 101
Dover, DE 19904
Ph: 302-734-3376
Fax: 302-883-3935

353 Savannah Rd
Lewes, DE 19958
Ph:302-703-6585
Fax:302-703-6589

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Full Name (please print) *Date of Birth*

_____

Patient Signature

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below the names of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:
*The patient refused to sign.
*Due to an emergency, it was not possible to obtain an acknowledgement.
*We weren't able to communicate with the patient.
*Other (Please provide specific details)

_____
_____
_____

_____ _____

Employee Signature *Date*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices 2013

This form does not constitute legal advice and covers only federal, not state, law.

Burke Dermatology

Health History & Intake Form

Please Check All That Apply

Are we authorized to leave detailed voice messages including biopsy and culture results?

- ☐ Yes
- ☐ No

Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ Benign Prostatic Hyperplasia
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ COVID
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**

Other _____
_____
_____
_____
_____

Past Surgical History

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast Biopsy
- ☐ Breast Lumpectomy; Right, Left, Both
- ☐ Breast Mastectomy; Right, Left, Both
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart; Biological Valve Replacement
- ☐ Heart; Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart; Mechanical Valve Replacement
- ☐ Heart; PTCA
- ☐ Joint Replacement; Right, Left, Both
- ☐ Joint Replacement; Right, Left, Both
- ☐ Kidney; Biopsy, Stone Removal, Transplant
- ☐ Liver; Hepatectomy
- ☐ Liver Transplant
- ☐ Liver; Shunt
- ☐ MOHs Skin Cancer Surgery
- ☐ Ovaries Oophorectomy; Endometriosis
- ☐ Ovaries Oophorectomy; Cyst
- ☐ Ovaries Oophorectomy; Ovarian Cancer
- ☐ Ovaries; Tubal Ligation
- ☐ Prostate Cancer
- ☐ Rectum; APR
- ☐ Rectum; Lower Anterior Resection
- ☐ TURP
- ☐ Testicles (Orchiectomy)
- ☐ Uterus; Fibroids
- ☐ Uterus; Uterine Cancer
- ☐ Uterus; Cervical Cancer
- ☐ **NONE**

Health History Continued

Skin Disease History

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itching Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ **NONE**
- ☐ Other: _____

- ☐ **Do you tan in a tanning salon?**
- ☐ Yes
- ☐ No

Do you wear sunscreen?

- ☐ Yes, if Yes, what SPF? _____
- ☐ No

Alerts

- ☐ HIV Positive
- ☐ Latex Allergy
- ☐ Currently Pregnant or Planning Pregnancy
- ☐ Breast Feeding
- ☐ Becomes faint or dizzy with surgical procedures
- ☐ Blood Thinners
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ History of MRSA
- ☐ Allergic to Sulfa Drugs or Sulfa Creams
- ☐ Allergies to Adhesives
- ☐ Allergy to Topical Antibiotic
- ☐ Rapid Heartbeat with Epinephrine
- ☐ Allergy to Lidocaine
- ☐ Yeast Infections with Antibiotics
- ☐ GI upset with Antibiotics
- ☐ Active/History of Hepatitis
- ☐ West Africa; Travel or Contact
- ☐ **NONE**

Smoking Status

- ☐ Never Smoker
- ☐ Daily Smoker
- ☐ Former Smoker

Pneumonia Vaccine

(if over 65 years of age)

- ☐ Yes
- ☐ No

Family History

(Which Member)

Mother/M, Father/F, Sister/S, Brother/B, Uncle/U, Aunt/A, Grandmother/GM, Grandfather/GF

- ☐ **Melanoma**
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Seizures
- ☐ Malignancy
  - ○ Type _____
- ☐ Angina
- ☐ Respiratory Disease
- ☐ Breast Cancer
- ☐ Stroke
- ☐ Eczema
- ☐ Allergies
- ☐ Glaucoma
- ☐ **NONE**

Medications

_____

_____

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_____

Allergies

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