Martin B. Miller, M.D.

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Today's Date_____

Whom may we thank for referring you?

(Who is your family Doctor?)

PATIENT REGISTRATION

PATIENT INFORMATION:

PATIENT EMAIL			MARITAL STATUS Single ☐ Married ☐ Widowed ☐ Divorced ☐		
LAST NAME	FIRST	MIDDLE		SOCIAL SECURITY NO.	
ADDRESS STREET, APT., P.O. BOX	CITY	ZIP	SEX	BIRTHDATE	
HOME PHONE NO.	EMPLOYERS NAME		OCCUPATION		
EMPLOYER'S ADDRESS			EMPLOYER'S PHONE NO.		
NEAREST LIVING RELATIVE (NOT LIVING WITH YOU)	ADDRESS		PHONE NO.		
DRIVER'S LICENSE NO.	WHOM MAY WE CONTACT IN CASE OF EMERGENCY?		PHONE NO.		

PREFERRED PROVIDER ORGANIZATION (PPO) ARE THOSE INSURANCE COMPANIES WHICH OFFER A PANEL OF PHYSICIANS TO SELECT FROM. IF YOUR INSURANCE COMPANY IS A PPO, PLEASE CHECK THIS BOX ☐. WHAT IS THE AMOUNT OF YOUR CO-PAYMENT FOR OFFICE VISIT: _____

RESPONSIBLE PARTY - INSURED'S INFORMATION:

PRIMARY CARRIER INFORMATION: Patient's relationship to insured: self ☐ spouse ☐ child ☐

LAST NAME	FIRST	MIDDLE		SOCIAL SECURITY NO.	
ADDRESS STREET, APT., P.O. BOX	CITY	ZIP	SEX	BIRTHDATE	
HOME PHONE NO.	EMPLOYERS NAME		OCCUPATION		
EMPLOYER'S ADDRESS			EMPLOYER'S PHONE NO.		
INSURANCE COMPANY	GROUP NO.		POLICY ID NO. - SUBSCRIBER NO.		
ADDRESS STREET, P.O. BOX	CITY	STATE	ZIP		

SECOND INSURANCE INFORMATION:

Patient's relationship to insured: self ☐ spouse ☐ child ☐

LAST NAME	FIRST	MIDDLE		SOCIAL SECURITY NO.	
ADDRESS STREET, APT., P.O. BOX	CITY	ZIP	SEX	BIRTHDATE	
HOME PHONE NO.	EMPLOYERS NAME		OCCUPATION		
EMPLOYER'S ADDRESS			EMPLOYER'S PHONE NO.		
INSURANCE COMPANY	GROUP NO.		POLICY ID NO. - SUBSCRIBER NO.		
ADDRESS STREET, P.O. BOX	CITY	STATE	ZIP		

Please fill out information on reverse side

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to the physician/supplier for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ Beneficiary Signature

_____ Date

(OVER ➡)

MEDICAL HISTORY - Please answer all questions

(Your nurse will go over this information with you in the examination room)

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Yes	No
Good general health now	☐	☐
Asthma	☐	☐
Chronic Hay fever	☐	☐
Hives	☐	☐
Sinus problems	☐	☐
Migraines	☐	☐
Eczema	☐	☐
Boils	☐	☐
Food allergies	☐	☐
Allergy to local anesthetics	☐	☐

	Yes	No
Tuberculosis	☐	☐
Ulcer	☐	☐
Diabetes	☐	☐
Internal cancer	☐	☐
High blood pressure	☐	☐
Heart trouble	☐	☐
Rheumatic fever	☐	☐
Jaundice/Hepatitis	☐	☐
Kidney disease	☐	☐
Glaucoma	☐	☐
Epilepsy	☐	☐

Women Only:

	Yes	No
Are you pregnant?	☐	☐
Expected delivery date _____		
Are you breast feeding?	☐	☐
Do you take birth control pills?	☐	☐
Which Brand? _____		

What diseases, if any, run in your family? _____

_____

Please list all prescription and non-prescription medications you are taking or have taken recently for any problem including your skin: _____

_____

If you are allergic to any medications, please list them: _____

	Yes	No
Have you ever been treated for skin cancer?	☐	☐

Previous skin problems _____

Serious illness _____

Hospitalizations _____

_____

Surgery _____

CONSENT FOR TREATMENT OF MINOR

(Anyone under 18 years of age)

For a minor: I consent to have Dr. Miller or his associates provide medical care for _____ (name of patient)

in my absence. I **would** or **would not** like to be consulted prior to minor procedures such as mole removal, acne treatment and wart treatments. (circle one)

_____ (Signature of Parent or Guardian)

_____ (Witness)

ALL PATIENTS PLEASE SIGN

RELEASE AUTHORIZATION / ASSIGNMENT OF BENEFITS:
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS.
I ALSO AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED PHYSICIAN OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ SIGNED (INSURED PERSON)

_____ DATE

Martin B. Miller, M.D. FAAD
Diseases and Surgery of the Skin

Financial Policy

Thank you for choosing us as your skin care provider. We are committed to providing you with the best dermatologic care available. The following is a statement of our Financial Policy. *Please read carefully and sign to acknowledge your understanding and agreement.*

Insurance Plans in Which We Are a Participating Provider
For covered services, we ask that all co-payments and deductibles be paid on the day of treatment. For services that are not covered by your insurance, we ask that you pay the entire fee the day of your treatment.

At the time of your service, if we/you believe you have valid insurance coverage, but later find out, for whatever reason, you were not covered, you acknowledge and agree you are responsible for the entire fee.

Insurance Plans in Which We Are Not a Participating Provider
For those plans in which we are not a participating provider, or once were but are no longer, we ask that you pay the entire professional fee at the time of your visit.

Usual and Customary Fees
Our practice is committed to providing the highest level of professional care and service we can. Our fees are based on many factors including skill, care and judgment of our staff, quality of supplies and equipment, and our ongoing professional continuing education.

Insurance companies may arbitrarily determine a "geographic usual and customary fee." Any insurance company determination of what is usual and customary will not impact the quality of care you receive so you will be responsible for our entire professional fee (Does not apply to *covered* services for insurance plans in which Dr. Miller is a participating provider).

Unpaid Accounts
Accounts unpaid over 30 days may be subject to a monthly finance charge. Accounts unpaid over 90 days will be considered delinquent and may be subject to collection procedures. If your balance becomes delinquent and collection procedures become necessary, you are responsible for all the collection costs, court costs, and/or attorney's fees incurred by Dr. Miller and/or his staff or representatives.

Missed Appointments/Late Cancellations
There may be a charge for missed appointments unless 24-hour advance notice is given. ($50 for office visits; will be higher for missed surgical procedures.)

I have read the above paragraphs and understand their contents and agree to the provisions stated in them.

_____ _____
Patient's signature Date

_____
Print name