Atlantic Dermatology
& Laser Center
Patient Registration
All information must be completed. Please print clearly

Dermatologix, Inc
PO Box 107
Linwood, NJ
08221

Patient
Last Name _____ MI ____
First Name _____ Age ____
Address _____
City _____ State ____ Zip _____
Home Phone (___) ____ - _____ Sex: M ☐ F ☐
Birth Date _____ Soc. Sec # ____ - ___ - ____
Status Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Policy Holder / Insured (Leave blank if same as patient.)
Last Name _____
First Name _____ MI ____
Address _____
City _____ State ____ Zip _____
Home Phone (___) ____ - _____ Sex: M ☐ F ☐
Birth Date _____ Soc. Sec # ____ - ___ - ____
Relationship of Patient to Insured Self ☐ Spouse ☐ Child ☐

Employment Status Full time ☐ Part time ☐ Employed since ___ / ___ Retired ☐ Not Employed ☐ Student ☐
Patient Employed by _____ Address _____
City, State, Zip _____ Work Phone (___) ____ - _____ Occupation _____

Insurance Information
Primary Insurance Co _____ Group # _____ ID# _____
Insured / Policy Holder _____ Birth Date _____ Referral # _____ Visits# _____
Secondary Insurance Co _____ Group # _____ ID# _____
Insured / Policy Holder _____ Birth Date _____ Referral # _____ Visits# _____

Patient Information
Referred to office by Dr _____ of _____ Pharmacy _____

How did you hear about our practice?

- ☐ The Current: If the current, which edition?
  - ☐ Linwood/Northfield/Somers point
  - ☐ Egg Harbor Township
  - ☐ Margate, Ventnor, Longport
  - ☐ Ocean City
  - ☐ Hamilton Twp, & Egg Harbor City
  - ☐ Absecon & Galloway
  - ☐ Cape May
  - ☐ Middle Twp, Stone Harbor, Avalon
- ☐ Atlantic City Press
- ☐ Hammonton News
- ☐ Hammonton Gazette
- ☐ Yellow Pages
- ☐ Television
- ☐ Friend
- ☐ Other: _____

OFFICE VISITS NOT COVERED BY INSURANCE AND COPAYS ARE PAYABLE ON THE DAY YOU ARE SEEN.

I request that payment of authorized benefits be made either to me or on my behalf to Joseph J Hong MD for any services furnished to me by Joseph J Hong MD. 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 for related services. I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Legal Guardian: _____ Date ___ /___ /___

Financial Responsibility
This information is accurate and true to the best of my knowledge. I understand that if my insurance company denies the claim then I am responsible for payment for all services rendered.

Signature of Patient or Legal Guardian: _____ Date ___ /___ /___

*** Be added to our mailing list for any upcoming newsletters, mé product information, special offers, and updates!

Email Address _____ (email addresses will be used in our computer system only)

Atlantic
Dermatology
& Laser Center

Please fill out all fields

Name: _____ **Birthdate**_____

Sex: ☐male ☐ female

Reason for Visit Today: _____

Past Medical History: Check if you have been diagnosed with any major medical problems

☐ Stroke	☐ Kidney Disease	☐ Liver disease	☐ Eczema	☐ Skin Cancer:
☐ Glaucoma	☐ High blood pressure	☐ GI bleed	☐ Asthma	☐ Basal Cell Carcinoma
☐ Arrhythmia	☐ Heart attack/Angina	☐ Reflux	☐ Hepatitis	☐ Squamous Cell Carcinoma
☐ Tuberculosis	☐ Mitral valve prolapse	☐ Ulcer	☐ HIV/AIDs	☐ Melanoma

Past Surgical History (if skin cancer removal, specify location):

Operation (location) Date

1. _____
2. _____
3. _____
4. _____

Medications: (list current medications, including **Aspirin** and **Birth Control Pills**) ☐ **NONE**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergies: (List medications you are allergic to) _____

Family History - have any relatives been diagnosed with:

☐ Basal cell carcinoma	☐ Melanoma	☐ Eczema
☐ Squamous cell carcinoma	☐ Asthma	☐ Psoriasis

Have you ever smoked? _____ If yes, how much? _____

Do you use alcohol? _____ If yes, how much? _____

Are you currently pregnant or breast-feeding? _____

Are you planning on becoming pregnant in the next 6 months? _____

Occupation/Profession: _____

Review of Systems: (check all that apply)

Eyes

- ☐ Vision loss
- ☐ Blurred vision
- ☐ Corrective lenses

Ears, Nose, Throat

- ☐ Loss of smell
- ☐ Hearing loss
- ☐ Hoarseness

Cardiovascular

- ☐ Chest pain
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Artificial valve

Respiratory

- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath

Endocrine

- ☐ Excessive thirst
- ☐ Hot/cold intolerance
- ☐ Skin rash
- ☐ Impotence

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Black stools
- ☐ Indigestion
- ☐ Jaundice

Musculoskeletal

- ☐ Joint swelling
- ☐ Back pain
- ☐ Bone pain
- ☐ Artificial Joint

Neurological

- ☐ Numbness
- ☐ Weakness
- ☐ Tremor
- ☐ Seizure

Hematological

- ☐ Swollen glands
- ☐ Prolonged bleeding
- ☐ Easy bruising
- ☐ Frequent infections

Psychiatric

- ☐ Anxiety
- ☐ Suicidal
- ☐ Psychosis

Constitutional

- ☐ Anorexia
- ☐ Weight Loss
- ☐ Fatigue

Gynecological

- ☐ Irregular periods
- ☐ Excessive cramping
- ☐ Excessive bleeding
- ☐ I could be pregnant
- ☐ Date of last period _____

Patient Signature: X _____ **Date**: ____

Individual Patient's Authorization

I give my authorization to use or disclose my health information to the following people and organizations:

__√____ The staff of Atlantic Dermatology and its billing company.

__√____ My insurance company(ies) and their representatives

__√____ Other physicians involved in my health care

__√____ My pharmacy

_____ My spouse _____
spouse's name

_____ My child(ren) _____
child(ren)'s name(s)

_____ Other _____
(please specify)

Patient Communications

Home phone

____ Atlantic Dermatology may leave a message on my home phone with detailed information.

____ Atlantic Dermatology may leave a message on my home phone with call back number only.

Work phone

____ Atlantic Dermatology may leave a message on my work phone with detailed information.

____ Atlantic Dermatology may leave a message on my work phone with call back number only.

Written Communications

____ Altantic Dermatology may send mail to my home address.

____ Altantic Dermatology may send mail to my work address.

_____ Atlantic Dermatology may send a fax to me at my request.

Revoking Authorization

I understand that I may revoke this authorization at any time by giving written notice to Atlantic Dermatology. However, I understand the revocation will not be effective for any actions taken prior to receipt of the written notice. I understand that I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke the authorization, the insurance company may contest my claims under the policy.

Signature: _____ Date: _____

Printed Name: _____