John M. Tieman, MD PA
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PATIENT REGISTRATION

PLEASE PRINT

NAME _____

ADDRESS_____

MAILING ADDRESS _____

CITY_____ STATE _____ ZIP _____

SEX_____ DATE OF BIRTH_____ SOCIAL SECURITY #_____

EMAIL ADDRESS_____

HOME (_____)_____ WORK (_____)_____ CELL(____)_____

WHEN CONTACTING ME (please check all that apply):

__ Leave a message with a call back number only
__ Leave medical information with my spouse/domestic partner
__ Do not leave a message
__ Leave a message with detailed information

PRIMARY INSURANCE_____
MEMBER ID#

INSURED_____
NAME RELATIONSHIP TO PATIENT DOB SOCIAL SECURITY #

SECONDARY INSURANCE_____
MEMBER ID#

INSURED_____
NAME RELATIONSHIP TO PATIENT DOB SOCIAL SECURITY #

NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO USE HEALTH INFORMATION

This authorization is effective for all my records, including past records, and remains effective until it is revoked in writing.

- Tieman Dermatology has made the Notice of Privacy practices available to me.
- Tieman Dermatology may access, collect, use and disclose my health information to my primary care or referring physician. To consultants, and as necessary to others to process insurance claims, insurance applications, and prescriptions.
- Tieman Dermatology may also disclose my health information to the following people:

Name:_____ Phone: _____ Relationship to Patient:_____

Name:_____ Phone: _____ Relationship to Patient:_____

__ MAY NOT release records: (please specify):_____

Signature: _____ **Date**: _____

INSURANCE BILLING AUTHORIZATION

I authorize Tieman Dermatology to release information concerning my medical treatment to my insurance company as necessary for processing claims. I also authorize Tieman Dermatology to receive direct payment from my insurance company, including Medicare or Medicare Replacement Plan, for services rendered. I understand that I am responsible for any co-payments, deductibles, or other charges for services that are not paid by my insurance.
I understand if **I do not have insurance**, the total cost of my services that day is due in full at the end of my appointment.

OUR CANCELLATION POLICY

Because we reserve a time especially for you, we require a 24-Hour notice of cancellation. Please cancel before the 24-hour period to avoid the $25 late cancellation fee.

Signature: _____ **Date**: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (enlarged prostate)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
Colitis or Crohn's disease
COPD
Coronary Artery Disease
Depression
Diabetes
Kidney Disease
GERD (Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other _____

Past Surgical History: (please circle all that apply)

Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Colon surgery: (Cancer, Colitis, Crohn's)
Gallbladder Removed
Coronary Artery Bypass
Heart Stents
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Pacemaker
Knee Replacement (Right, Left, Bilateral)
Hip Replacement (Right, Left, Bilateral)
Kidney Removed (Right, Left)
Kidney Transplant
Ovaries Removed: (Cyst, Cancer)
Prostate Removed: Cancer
TURP (prostate)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: (Cancer, Fibroids)

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses (pre-cancer)
Basal Cell Skin Cancer
Blistering Sunburns
Eczema
Hay Fever/Allergies
Melanoma
Psoriasis
Squamous Cell Skin Cancer
Other _____

Name: _____ ***Date:*** _____

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 Skin Cancer? Yes No

If yes, what type of skin cancer? _____

Which Relative(s)? _____

Medications: (If you have a list, we will copy it)

_____
_____
_____

Medication Allergies: (Please enter all allergies to drugs)

_____
_____

Preferred Pharmacy: _____City_____

Primary Care Provider: _____ City_____

If you are female: Are you pregnant or trying to get pregnant? Yes No
Are you nursing or breastfeeding? Yes No

Social History: (Please circle all that apply)

Cigarette Smoking: Never Former smoker Occasional smoker Smokes daily

Alcohol Use: None Less than 1 drink/day 1-2/day More than 3/day

Preferred Language: English Other _____

Race: White/Caucasian Hispanic/Latino
Black/African American Native American
Asian Other _____

Name: _____ ***Date:*** _____