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14305 Southcross Drive West, Suite 110
Burnsville, MN 55306
651-340-1064
14001 Ridgedale Drive, Suite 300
Minnetonka, MN 55305
763-316-4407

Today's Date: _____

Patient Registration Information

Last Name: _____ **Legal First Name**: _____ **MI:** _____
Date of Birth: _____ **Age:** _____ **Gender:** ☐ **F** ☐ **M**
Home Street Address: _____**Apt/Unit #:** _____
Home City, State, Zip: _____
Please circle one of the following: ☐ Married ☐Single ☐Divorced ☐Widowed ☐Separated

Race/Ethnicity: ☐Asian ☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander ☐Black or African American ☐White ☐ Hispanic ☐ other _____
Is English your primary language? YES / NO If no, language: _____

How may we contact you regarding medical information and results? (If patient is under 18, provide parent/guardian contact information) _____

1) **Home/Cell/Work:** _____ ☐No message ☐Message to call back ☐Detailed message
(Number)
2) **Home/Cell/Work**: _____ ☐No message ☐Message to call back ☐Detailed message
(Number)

Emergency Contact Name/Phone: _____

Our EMA Patient Portal allows you to access your Lakes Dermatology, P.A. medical information

□ No, I do not want to provide my email address. (We will not share your email address)
□ Yes, I want to participate in the patient portal. Email: _____
□ Yes, you may upload my prescription information from outside providers for continuation of care.
□ Yes, please contact me for news and events in our practice. Email: _____

INSURANCE INFORMATION**WHEN YOU CHECK IN, YOU MUST PRESENT YOUR INSURANCE CARD AND PHOTO ID IN ORDER FOR US TO SUBMIT CLAIMS TO YOUR INSURANCE**

Primary Medical Insurance Company _____
ID #: _____ Group #: _____
Policyholder information (if different from patient):
Self/Name: _____ Date of Birth ___/___/_____ Relationship: _____
Address: _____
Secondary Medical Insurance Company (if applicable) _____
Group #_____ Policy #_____
Policyholder information (if different from patient):
Self/Name: _____ Date of Birth ___/___/_____ Relationship: _____
Pharmacy Benefits Company (if different from above) _____
ID #: _____ PTAN #: _____

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How did you hear about us?

☐ Referring Physician/Clinic: _____
☐ Internet Search ☐ Drive By ☐ Insurance Company ☐ I'm an Established Patient
☐ Other: _____

Authorization to discuss medical related information:

This authorization allows Lakes Dermatology, P.A. to discuss **ALL ASPECTS** of my protected health information and treatment including but not limited to test results, biopsy results, billing information and prescription information with the individual(s) listed below:

Name: _____ Relationship: _____ Phone: _____
First Last

Name: _____ Relationship: _____ Phone: _____
First Last

Please initial and sign below.

Initial: _____ **Medical Information Release**: I authorize the release of medical information to any physician/healthcare provider involved in my care including my primary care or referring provider, to consultants and also as necessary to process insurance claims and applications and to any person or entity outside of Lakes Dermatology, P.A. for purposes of Lakes Dermatology, P.A. health care operations. If I wish for anyone else to have access to my medical records, I will ask for a Medical Record Release Form to name these people.

Initial: _____ **Financial Policy**: I have read and agree with Lakes Dermatology's financial policy.

Initial: _____ **Assignment of Benefits**: I hereby request that payment of Medicare or insurance benefits be made directly to Lakes Dermatology, P.A. on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If for any reason my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

Initial: _____ **Consent for treatment:** By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that this could include lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment and that I have the right to refuse the recommended treatment.

Initial: _____ **Notice of Privacy Practices:** I acknowledge I have been made aware of Lakes Dermatology, P.A.'s privacy practices. I understand a copy of Lakes Dermatology, P.A.'s privacy practices will be made available to me upon request. I consent to be contacted by Lakes Dermatology, P.A. or their business associates at the physical address, phone numbers, and email address provided.

I _____ have read and agree with the above. I have filled this form out to the best of my ability and will notify Lakes Dermatology, P.A. of any changes in my information.
Patient/Responsible Party (print)

_____ _____
Signature **Date**

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Medical History Form

Name: _____ Date of Birth ____/_____/_____
How did you hear about Lakes Dermatology? _____
Primary care doctor/Clinic: _____
Preferred pharmacy: _____
What is the reason for your visit today? _____
_____
Have you used any treatments for this condition? If yes, please list: _____
_____
When was your last skin check? _____

Past Medical History

Please check if you have a history of the following:

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Autoimmune disease
☐ Bone Marrow Transplantation
☐ Breast Cancer
☐ Bleeding disorder
☐ Colon Cancer
☐ COPD
☐ Depression
☐ Diabetes
☐ Kidney disease
☐ GERD or reflux
☐ Hearing loss
☐ Hepatitis
☐ High Blood Pressure
☐ HSV/cold sores
☐ HIV/AIDS
☐ High Cholesterol
☐ Joint Replacement within last 2 years
☐ Thyroid disease
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Radiation treatment
☐ Seizures
☐ Stroke
☐ Polycystic Ovarian Syndrome
☐ Other Cancer: _____ _____

Other: _____

Have you ever been diagnosed with COVID-19? ☐ YES or ☐ NO If yes, date:_____
Have you received a COVID-19 vaccine? ☐ YES or ☐ NO If yes, date:_____
Have you received a Flu vaccination in the last year? ☐ YES or ☐ NO
If not, please state reason: _____
If over age 65, have you ever received a Pneumococcal vaccination? ☐ YES or ☐ NO
If 18 or under, please indicate your approximate weight: _____ and height: _____

Skin Disease History

Please check if you have a History of the following:

☐ Acne
☐ Actinic Keratoses
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry skin
☐ Eczema
☐ Hay fever or allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ Flaky/itchy scalp
☐ Other: _____

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Family History

Do you have a family history of Melanoma? ☐ No ☐Yes:
Whom: _____

Do you have a family history of other skin cancer? ☐ No ☐ Yes
Whom and type: _____
Other Family History: _____
_____

Are you pregnant or planning a pregnancy? ☐ No ☐ Yes

Are you breastfeeding? ☐ No ☐ Yes

Are you on birth control? ☐No ☐ Yes What Type: _____

Social History

Occupation: _____

Do you wear sunscreen? ☐ No ☐ Yes SPF: _____

Have you ever used a tanning bed? ☐ No ☐ Yes If yes, how often: _____

Do you currently use tobacco? ☐ No ☐ Yes
If yes, type of tobacco and frequency_____

Were you a former tobacco user? ☐ No ☐ Yes
If yes, type of tobacco used? _____

Do you use alcohol? ☐ No ☐ Yes

Medications

Name	Dose	Route (e.g. oral)	Frequency (e.g. twice daily)

Please attach a separate list or give to your nurse, if needed

Medication or Other Medical Allergies (check all that apply)

☐ Latex ☐ Adhesives ☐ Lidocaine or numbing medication ☐ I have allergies to the following medications (please list):

_____

☐ No allergies to medications

Do you currently have any of the following symptoms?

Fever or chills	☐No ☐Yes	Abdominal pain	☐No ☐Yes
Night sweats	☐No ☐Yes	Nausea or vomiting	☐No ☐Yes
Fatigue	☐No ☐Yes	Constipation or diarrhea	☐No ☐Yes
Unexplained weight loss	☐No ☐Yes	Rash or itchy skin	☐No ☐Yes
Swollen lymph nodes	☐No ☐Yes	Problems with scarring	☐No ☐Yes
Joint pain	☐No ☐Yes	Seasonal allergies	☐No ☐Yes
Muscle Weakness	☐No ☐Yes	Depression or Anxiety	☐No ☐Yes
Headaches	☐No ☐Yes	Immunosuppression	☐No ☐Yes
Seizures	☐No ☐Yes	Hair loss	☐No ☐Yes
Blurry vision	☐No ☐Yes	Blood thinners	☐No ☐Yes
Chronic cough	☐No ☐Yes	Blood clots	☐No ☐Yes
Shortness of breath	☐No ☐Yes	Sore throat	☐No ☐Yes
Chest pain	☐No ☐Yes	Artificial heart valve	☐No ☐Yes
Pacemaker or defibrillator	☐No ☐Yes	Other Symptoms:	☐No ☐Yes

List: _____

Is there anything else in your history that we should be aware of?

_____

_____

Signature of Patient (or Guardian) _____

Date: _____

If signed by a guardian, please describe the relationship to the patient:

_____

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Financial Policy

Thank you for trusting your medical care to Lakes Dermatology. We strive to render excellent care to you, your family, and all of our patients. We ask that you review our Financial Policy below that includes more information on your financial obligations when services are rendered to you. We look forward to seeing you!

Insurance:

- Lakes Dermatology specializes in Dermatological care so your medical services are considered medically necessary or Cosmetic but never preventative. **Preventative care** is provided by your Primary Care Provider or Specialty providers who render service that your Primary Care Provider cannot render (example: Colonoscopy or Mammogram). There are no preventative codes in Dermatology for us to submit to insurance. We will gladly file your insurance claim on your behalf to the companies with which we participate. We allow 45 days for your insurance company to process the claim. If the insurance company does not process your claim within that time, you will be responsible to pay the entire amount. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria such as deductibles, copays, co-insurance, non-covered services, and coordination of benefits.
- You should confirm that Lakes Dermatology is “in-network” with your insurance plan. Contact your insurance company prior to your visit to clarify your covered benefits for Dermatology. If we are considered "out-of-network", you are responsible for full payment at the time of service. You can then submit the itemized bill to your insurance if allowable.
- Lakes Dermatology accepts many insurance carriers, PPO’s, and HMO’s. Charges for the services billed to our contracted insurance carriers will be discounted to their allowed amount. You are responsible for any copays, deductibles, any non-covered services, and usual and customary amounts for non-contracted insurance. There may be some networks within these insurance carriers that we are not contracted with and it is your responsibility to know if we are considered in-network or not. Also, if your insurance requires a referral, you must obtain one prior to your visit.
- Please bring your current medical insurance card to every visit and notify us if there is a change in your insurance coverage.
- If your insurance requires a referral, you must obtain one prior to your visit.
- Co-payments are due at the time of check-in along with any amount due on your account. If you are unsure of your copay, deductible, or coinsurance amount please contact your insurance company for clarification prior to your appointment.
- You will be asked to sign an Authorization and Release of Information form, which allows us to bill and receive payment from your insurance company.

Patients Without Insurance:

- If you do not have insurance, or your insurance company does not cover your services, we require that you pay cash at service. Make sure your provider is aware that you are cash pay and discuss costs before procedures.

Cosmetic Services:

- Cosmetic services are not covered by insurance and must be paid in full at the time of service if prepayment has not been made.
- Payment in full is required at the time of scheduling for Sculptra.
- A $100 deposit is required to reserve certain cosmetic appointments. This will be applied to your cosmetic services that day. If you cancel less than 24 hours (or 72 hours) in advance, the deposit of $100 will be lost

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Laboratory Services:

- If you receive laboratory services such as blood tests, you may receive a bill from Quest Diagnostics Laboratories as they perform the analysis of the lab specimen.

Pathology Services:

- If you have a tissue biopsy done, you may receive a separate bill from Aurora Diagnostics in addition to your bill from Lakes Dermatology, as their pathologists perform the analysis of tissue. Lakes Dermatology will bill for the biopsy and technical processing of the tissue sample.
- There may be times where additional diagnostic testing needs to be done which may require additional charges.

Appointment Cancellation Policy:

- Your appointment is reserved especially for you. Should you need to cancel or change the date of your appointment, we would appreciate 72 hours' notice. This allows the appointment to be given to another patient in need of care.
- A patient who fails to show up for a scheduled appointment without prior notice will be considered a "no-show". Patients who no show or cancel two times without 72 hours' notice may be considered for dismissal from the practice.

Billing:

- You will receive an itemized statement monthly, and payment is due within 30 days of the statement date. If you are unable to pay the balance in full, please contact our billing office immediately to preserve your credit.
- We accept: cash, check, and credit cards.
- If you would like to pay your statement with a credit card, please call our billing department at 612-404-0777 to do so.
- You are ultimately responsible for all fees relating to your care.
- Any balances that have been unpaid for a period of 60 days or longer will be sent a notice letter. This is the final opportunity that you have to resolve your account. If no contact is made to our office, your account may be sent to our legal collection agency. All contact regarding your account must then be made with the legal collection agency's account representative.
- Please report all address, insurance, and/or telephone changes promptly by calling our office.
- Responsibility for minor/dependent accounts rests with the legal guardian and we may ask for proof of guardianship. Any court ordered responsibility judgement must be determined between the individuals involved.
- If at any time you have questions regarding your bill, please call our billing department at 612-404-0777 and we will be happy to assist you.

Patient Satisfaction:

- Lakes Dermatology takes pride in the services that we provide to our patients. It is important to us that our patients are the center of our practice. Our goal is to provide you with the highest quality of care in a courteous and professional setting. If at any time your experience with us did not meet your expectations, please contact us to report your question, issue, or concern.

_____ _____

Name of Patient (please print) Signature

_____ _____

Patient/Responsible Party if under 18 Signature Date