SHERRY LI, MD, PHD
LI DERMATOLOGY, PLLC

Registration Form

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

Name (Last, First) _____ Date of Birth: ____/____/____ Sex: ☐ M ☐ F

SSN _____ Marital Status: S M W Language _____ Race _____

Address _____City_____State_____ Zip _____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Email _____ Occupation _____ Employer _____

Emergency Contact _____ _____ _____
Name Address Phone Relationship

INSURED OR RESPONSIBLE PARTY ***(if different from patient)***

Name (Last, First) _____ Date of Birth: ____/____/____ Relationship Mother Father Spouse Other

Address:_____Phone: _____

Primary Care Physician _____
Name Address Phone

Referred by_____

Primary Insurance Carrier: _____Secondary Insurance Carrier: _____

Primary Pharmacy _____
Name location City phone

ACKNOWLEDGEMENT OF HIPPA NOTICE OF PRIVACY PRACTICES

I hearby acknowledge that I have fully reviewed and/or have received a complete copy of the HIPPA notice of privacy practices provided by the staff of this office.

SIGNATURE _____ Relationship to the patient, if signed by a representative_____

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PHI

I request confidential communication of my protected health information, and I have designated the following method of contacting:

_____
Name Address City State Zip

Phone_____ Mobile _____

It is our policy to maintain a credit card on file; should the account fall into arrears greater than 60 days, I authorize the unpaid patient due balance to be charged to my credit card #: _____, exp _____ If I do not a valid credit card on file and additional statement has to be sent for collection of the due balance, additional $10 administrative fee will be added to the balance.

ASSIGNMENT OF INSURANCE BENEFIT:

I hereby authorize direct payment of surgical/medical benefits to LI DERMATOLOGY, PLLC for service rendered by Dr. Sherry Li or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE/ MEDICAID: I certify that the information given by me in applying for payment is correct. I authorized release of all records on request. I request that payment of authorized benefits be made on my behalf.

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL

PATIENT NAME (PRINT) _____ PARENT/ GUARDIAN (PRINT)_____

SIGNATURE _____ DATE _____

(Turn Over)

Name _____

Medical History Intake

PLEASE CIRCLE THE APPROPRIATE ANSWER:

Have you ever been diagnosed for any of the following?

- **duodenal or peptic ulcer or acid reflux**
- **tuberculosis or lung disease**
- **heart murmur/coronary art disease/ arrhythmia**
- **high blood pressure**
- **thyroid problem**
- **blood clot**
- **kidney disease**
- **hepatitis or liver disease**
- **emotional disorder**
- **diabetes**
- **bleeding disorder**
- **joint replacement**
- **immunodeficiency disorder**
- **artificial heart valve**
- **Botox or fillers**
- **Chemical peel and other cosmetic treatment**

Have YOU or any relatives ever had

- **difficulty with the healing of wounds?**
- **excessive bleeding when cut?**
- **overgrown scars or keloids?**
- **x-ray treatment for skin conditions?**
- **tanning bed usage?**
- **Eczema?**
- **allergies /asthma?**
- **severe acne?**
- **large or unusually numerous moles**
- **skin cancer?**

Have you had any surgery?

Do you take antibiotics routinely before surgery?

Do you take aspirin OR blood thinners?

Do you have a PACEMAKER?

Are you on special diet?

Please specify is YES _____

Smoking history: **Currently everyday smoker** **Currently someday smoker** **Former Smoker** **Never smoked**

FOR FEMALES

Do you have regular menstrual cycle? **YES _____ NO**

Are you now pregnant, planning a pregnancy in the near future, or nursing a child? **YES _____ NO**

(if yes, please specify) _____

MEDICATION & ALLERGY

Are you ALLERGIC to any medication or substance? **YES _____ NO**

If YES, please list the medication and reaction _____

CURRENT MEDICATION

Medication _____ Indication_____ **Medication _____ Indication_____**

Medication _____ Indication_____ **Medication _____ Indication_____**

Medication _____ Indication_____ **Medication _____ Indication_____**

Medication _____ Indication_____ **Medication _____ Indication_____**

Vitamins / supplements _____

Signature _____ Date _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form

Name _____

(Turn Over)