JACKIE M. TRIPP, M.D., P.L.C.
5130 LINTON BOULEVARD, SUITE C1 • DELRAY BEACH, FLORIDA • 33484
PHONE : 561-819-6888 • FAX : 561-819-5448

PATIENT REGISTRATION FORM

PATIENT NAME:_____DATE OF BIRTH:_____AGE_____

LOCAL ADDRESS:_____
Street City State Zip

HOME PHONE NO.( )_____CELL NO.( )_____WORK NO.( )_____

OUT OF TOWN ADDRESS:_____OUT OF TOWN PHONE #( )_____
Street City State Zip

MARITAL STATUS ___S___M___W___D___SEP___SPOUSE NAME_____ BIRTHDATE_____

SOCIAL SECURITY #_____OCCUPATION_____

New federal guidelines require asking these questions.
EMPLOYMENT STATUS:__Employed__FT student__PT student__Retired__Self Employed _____Other
ETHNICITY:___Not Hispanic or Latino ___Hispanic or Latino ___I choose not to specify
RACE: ___White ___Am Indian/Alaskan Native ___Black/African American ___Asian ___Native Hawaiian ___Choose not to specify _____Other
PREFERRED LANGUAGE: ___English ___Spanish ___American Sign ___Choose not to specify _____Other

IN CASE OF EMERGENCY CONTACT:_____PHONE NO.( )_____RELATIONSHIP_____

PERSON RESPONSIBLE FOR PAYMENT:_____RELATIONSHIP_____

ADDRESS:_____PHONE NO.( )_____
Street City State Zip

METHOD OF PAYMENT: ___CASH___CHECK___CHARGE **REFERRED BY:**_____
Circle one: Physician, Friend, Relative, Other

PRIMARY CARE DR:_____

ADDRESS:_____PHONE NO.( )_____
Street City State Zip

PHARMACY INFO: _____**PHARM PH #**( )_____

OUT OF TOWN DERMATOLOGIST:_____ DERM PHONE NO. ( )_____

MEDICARE PATIENTS

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES CAN BE MADE.
Have you met your Medicare yearly deductible? ___Yes___No Secondary yearly deductible? ___Yes___No
Have you recently joined an HMO? If yes, identify_____
Are you covered by a HMO/PPO which makes Medicare your secondary insurance? _____Yes____No
Primary Insurance: Your cards will be copied. Medicare ID#: Your cards will be copied.
Secondary Insurance: Your cards will be copied. Secondary Ins ID#: Your cards will be copied.

(Medicare patients are fully responsible for their yearly deductible and 100% of the allowable Medicare Fee. Medicare pays 80% of this fee. You, the patient, are responsible for the full 20% Medicare does not pay. This includes any amount of the 20% the coinsurance or Medigap policy does not pay). Please read and sign our financial policy. Copies of "clinical summary" available within 3 days.

I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to any carrier, referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize payment of medical benefits be made on my behalf to Jackie M Tripp MD PLC.

****I acknowledge I was made aware of this practice's Notice of Privacy Practices.** _____ **(Initials of patient or legal guardian)**

****Do we have permission to leave a message on your answering machine at home?** ___Yes___No

****Discuss your medical condition with any member of your family? If yes whom?** _____ **Relationship**_____

_____ _____
PATIENT SIGNATURE (OR LEGAL GUARDIAN) **DATE**

JACKIE M. TRIPP, M.D., P.L.C. • DERMATOLOGY AND CUTANEOUS ONCOLOGY
5130 LINTON BOULEVARD, SUITE C1 • DELRAY BEACH, FLORIDA • 33484
PHONE : 561-819-6888 • FAX : 561-819-5448

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to seeing the doctor.

We are a Classic Medicare participating provider, and although we are always making inquiries to be registered with managed care plans, we are as of yet not contracted with any HMO/PPO companies. If you have Classic Medicare, you will be responsible at the time of service for payment of the following:

a) The annual Medicare deductible.
b) Co-insurance (the 20% that Medicare allows, but does not pay). This may be covered by your secondary or Medigap policy.
c) Co-payments of your secondary or Medigap insurance.
d) Charges for non-covered or cosmetic services.

(Medigap is a Medicare supplemental policy offered by private insurance carriers to supplement "covered" services through Medicare. Medicare will "crossover" insurance claims to these private insurers when the Medigap policy is in force. *NOTE * Not all secondary insurance policies are Medigap. Please check with our staff if you should have a question regarding your secondary insurance.)

If you have Classic Medicare, as well as secondary coverage with a Medigap plan, we will bill Medicare, who will automatically request payment to us from your Medigap plan for the remaining 20% (minus your co-payment).

If you have Medicare, you may be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by Medicare.

If you do not have coverage through Classic Medicare, but you have an insurance policy that will pay the practice directly, and that we can verify beforehand with the insurance company, we still require that you pay all co-payments, deductibles, co-insurance and charges for non-covered services at the time of service.

Payment is due at the time or service. We accept cash, checks, and credit cards.
All patients must also complete our Patient Registration Form. **It is understood that services rendered by the doctor are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of the doctor to collect from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Missed Appointments. If you are unable to keep an appointment. kindly give at least 24 hours notice. Please, help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns about the Policy or about a specific bill.
I have read the Financial Policy. I understand and agree to this Financial Policy.

Printed name of Responsible Party	Signature	Date
Printed name of Co-Responsible Party	Signature	Date

Jackie M. Tripp, M.D.
DERMATOLOGY AND CUTANEOUS ONCOLOGY
DIPLOMATE, AMERICAN BOARD OF DERMATOLOGY
FELLOW, ROYAL COLLEGE OF PHYSICIANS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Attention: _____
(Name of Doctor or Hospital)

_____
(Address of Doctor or Hospital)

_____ _____
(Phone Number of Doctor or Hospital) (FAX Number of Doctor or Hospital)

I hereby authorize and kindly request that you release my complete medical records in your possession, in relation to my illness and/or treatment during the period of:

From _____ Until _____
(day/month/year) (day/month/year)

To:
Jackie M. Tripp M.D, P.L.C. Dermatology
5130 Linton Boulevard, Suite C1
Delray Beach, Florida 33484
Tel: 561-819-6888

Fax: 561-819-5448

Please release: Pathology/biopsy results Progress Notes Lab results Procedure notes

Patient name: _____

Patient date of birth: _____

Patient address: _____

_____

Patient Signature: _____ Date: _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I specifically authorize the release of data and information relating to, if applicable, the following health information related to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, mental health, or drug and/or alcohol abuse. **I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

Jackie M. Tripp, M.D., P.L.C.
Dermatology and Cutaneous Oncology

HISTORY AND INTAKE FORM

PATIENT NAME (LAST, FIRST): _____

DATE OF BIRTH: _____/_____/_____

Preferred Language (circle): English / Other: _____

Race: _____ Ethnic Group: _____

ALERTS (PLEASE CIRCLE ALL THAT APPLY):

Allergy to adhesive
Rapid heartbeat with Epinephrine
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Defibrillator or Pacemaker
Blood thinner
History of MRSA
Pregnant/currently trying to get pregnant

FAMILY HISTORY (FIRST DEGREE RELATIVES WITH CANCER, HIGH BLOOD PRESSURE OR CHOLESTEROL):

_____

_____

Do you have a family history of Melanoma? No Yes (Relation: _____)

PAST MEDICAL HISTORY (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
High Blood Pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Seizures
Stroke

NONE

OTHER: _____

Do you tan in a tanning salon? No / Yes Do you wear Sunscreen? No / Yes, SPF: ____

SKIN DISEASE HISTORY (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaky or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

NONE

OTHER: _____

MEDICATIONS: (CURRENT LIST. ATTACH LIST IF NECESSARY) ☐ NONE

_____

_____

_____

ALLERGIES: (ENTER ALL ALLERGIES, WITH TYPE OF REACTION) ☐ NONE

_____

_____

_____

ARE YOU UP-TO-DATE WITH THE FOLLOWING VACCINATIONS?

Pneumonia (every five years) Yes / No Influenza ("the flu") Yes / No

CIGARETTE SMOKING (CIRCLE THAT WHICH APPLIES):

Never Smoked / Has smoked in the past / Currently Smokes / Former Smoker

ALCOHOL INTAKE (CIRCLE THAT WHICH APPLIES):

None / Less than 1 drink per day / 1-2 drinks per day / 3 or more drinks per day

ALSO: How many times in the past year have you had 4 or more drinks in a day?

None / Once / Twice / Other: _____