(Please Print) Account No. ___________________ Date______________________
Name of Patient ____ SS#__________________________________
Address ____City ______________________State _____ Zip_____________
Home Phone Number ( ) _________________________ Cell Phone Number ( ) __________________________________
Birth Date ____/___/_________ Sex ____ Age ____ Race ____ Marital Status __Single __Married __Other
If College Student, School Name ____ Full Time ___ Part Time ___
Employer ____ Work Phone ( ) ___________________________
Name of Spouse __________________________________ Spouse Phone Number ( ) _____________________________
Primary Care Physician _____________________________ Previous Dermatologist ______________________________
Did a Doctor send you to us? __ Yes __ No If so, whom? ____
Name of nearest relative: ____Phone # ( ) ____________________

COMPLETE THIS SECTION IF PATIENT IS A MINOR:
Fathers Name: _____________________________________
Address (if different) ______________________________
____
Phone # ____
Employer: ____

Mothers Name: _____________________________________
Address (if different) ______________________________
____
Phone # ____
Employer: ____

PRIMARY INSURANCE INFORMATION *(Please present card)*
Insurance Company ______________________________
Policy Holder _____________________________________
Date of Birth ____/____/_____
Relationship to policyholder ________________________
Policy Number____________________________________
Group Number ___________________________________

SECONDARY INSURANCE INFORMATION *(Please present card)*
Insurance Company ______________________________
Policy Holder _____________________________________
Date of Birth ____/____/_____
Relationship to policyholder ________________________
Policy Number ____________________________________
Group Number ___________________________________

If we participate in your insurance we **MUST** see and copy your card (electronic copies not accepted). *If you do not provide a card, we are **unable** to file and you will be responsible for **payment in full**.*
I have received and reviewed the "Office Policy ". (Signature) X____

PERSONAL MEDICAL HISTORY (Please check all that apply to **YOU**):

___ Diabetes	___Hepatitis	___ Hay Fever – Sinus	___Tuberculosis
___ High Blood Pressure	___ Stomach Ulcers	___ Arthritis	___ Dermatitis
___ Heart Disease	___ Leg Ulcers	___ Keloids	___ Skin Disease
___ Heart Pacemaker	___ Psoriasis	___ Bleeding Problems	___ Skin Cancer
___ Heart Murmur	___ Allergies	___ Glaucoma	___ Cancer (not skin)
___ Heart Valve	___ Asthma	___ Blood Clots (legs)	Type ________________

___ Other Medical Problems *(Explain)* ____
If Female, are you pregnant or planning to become pregnant in the near future? _______________________________

MEDICATIONS *(List ALL prescription and NON prescription medications – include laxatives, birth control pills, pain medications, etc.)*
____
____
____
(List medications you have had **ALLERGIES** or **REACTIONS** to, AND TYPE of reaction):_____________________________
____
____

FAMILY MEDICAL HISTORY (Please check any of the following conditions that apply to any member of your immediate **FAMILY**):
___ Allergies (If yes, explain) ____
___ Skin Diseases (If yes, explain) ____
___ Skin Cancer (If yes, explain) ____

PATIENT CONFIDENTIALITY FORM

Occasionally it is necessary for our office to call a patient regarding test results (example: notification of skin cancer), coordinate/discuss referral to another physician; discuss medication changes/refills. etc…

Please list the family members or other persons, if any whom we may inform, discuss or leave messages with about your general medical condition and your diagnosis (includes lab and pathology results) *Information is necessary when we cannot reach you.*

Name ___________________________ Relationship _________________ Phone # ____________________

Name ___________________________ Relationship _________________ Phone # ____________________

Name ___________________________ Relationship _________________ Phone # ____________________

Please print the telephone number where you want to receive calls about your appointment cancellations, lab and pathology results, or other healthcare information if other than your home phone number:

Work (____) _________________________ Cell (____) _______________________

Other (____) _________________________ Other (____) _____________________

Can confidential messages (i.e. messages to call the office regarding results or appointment cancellations) be left on your home answering machine or voicemail?

Yes ________ No ________

Can we call you at your place of employment if you cannot be reached at home?

Yes ________ No________

Patient Name ____

Signature ____ **Date** ______________

PHARMACY INFORMATION

Please complete this information even if you normally have your prescriptions filled at the Navy or Air Force Pharmacy.

Local Pharmacy

Name: ____________________________________
Intersection of: ____________________________
Address: __________________________________
____
Phone # __________________________________

Mail Order Pharmacy

Name: ______________________________________
Intersection of: _____________________________
Address: ___________________________________
____
Phone # ____________________________________

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Revised - September 25, 2008

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
The Department of Health and Human Services has established a "*Privacy Rule*" to help insure that *Personal Health Care Information* is protected for privacy by setting a standard for healthcare providers to follow and informing the patients of their rights regarding their medical records.

OUR OBLIGATION - The law requires us to:
1. Make sure that your health information is kept private.
2. Provide you this notice which describes our privacy practices and legal duties.
3. Provide you a new copy of the notice should we revise it.
4. Follow the term of the notice currently in effect.

As our patient we want you to know that we respect the privacy of your *Personal Health Care Information* and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those we feel are in need of your health information. Here is a list where disclosure of your *Personal Health Care Information* may occur:
1. Fulfill treatment - (interacting with physicians & laboratories, etc.)
2. Payment - (Billing of claims with personal information and release of records when requested by your insurance company.)
3. Business Associates - (Transcription Service, Billing Company, etc.)
4. Communication with family - (We may disclose to a family member, close friend or any other person **you identify** information regarding your care or discuss payment of services related to your care.)
5. When required by Federal, State or Local Law Enforcement - (Audits, warrants, subpoena, summons, etc.)

YOUR HEALTH INFORMATION RIGHTS - You have the right to:
1. Obtain a copy of your medical record upon request.
2. Inspect your medical record and request changes. The doctor has the right to refuse the changes.
3. Request a restriction on certain uses and disclosures of your information but we are not required to agree with the restrictions. This request must be in writing.
4. Revoke your authorization to use or disclose your *Personal Health Care Information* except to the extent that action has already been based on that authorization. Request must be in writing.
5. You may refuse to consent to the use or disclosure of your *Personal Health Care Information.* You should understand that under the law, we have the right to refuse to treat you should you choose to refuse to disclose your *Personal Health Care Information* .

I have read the above Privacy Notice and agree to the release of my *Private Health Care Information* under the guidelines listed above.

Print Name: ____

Signature: ____ **Date:** _______________