



NATURAL STATE DERMATOLOGY

NEW PATIENT INFORMATION:

Please provide your insurance card and a photo ID to the receptionist upon arrival.

Full Name: _____ **Preferred Name:** _____

DOB: _____ **Age:** ____ **Sex:** ____ **SSN:** _____ **Marital Status:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

Primary Care Physician: _____

Preferred Pharmacy/Location: _____

Do we have your permission to import your medications from your pharmacy? Yes No

If you select no, you will be required to provide a list of your medications.

In case of an emergency, who should we contact on your behalf?

Name: _____

Relationship to the Patient: _____

Phone Number: _____

___ I understand the rights of the Health Information Portability and Accountability Act of 1996 (**HIPAA**) and I am allowing **Natural State Dermatology** to discuss my medical care with the following individuals:

Name Phone Number Relationship

Name Phone Number Relationship

FINANCIAL AGREEMENT

Thank you for choosing Natural State Dermatology as your health care provider. The following is a statement of our financial policy:

Deductibles, copays and any uncovered services are due at the time of service. Fifty percent (50%) of the balance is due if a payment plan is requested. If your insurance requires a referral, it is your responsibility that one is provided. If you do not provide insurance information for your appointment, you will be considered self pay. Cash, checks, and credit cards are all accepted forms of payments. An adult must accompany a minor to their appointments.

I have read and understand how my physician desires to be compensated for the care I receive and I agree to be bound by these terms. I understand the laws of HIPAA and understand that NSD can only communicate with who is listed above.

Patient's Signature

Office Staff Signature

Date

Guardian's Signature (if patient is a minor): _____



PATIENT MEDICAL HISTORY

Name: _____ DOB: _____

What are you needing to be seen for today? _____

Personal History (Please check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV |

Other: _____

Past Surgeries/Hospitalizations:

1. _____
2. _____
3. _____

Skin History (Please check all that apply):

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Skin Cancer: _____ | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> AKs (Pre-Cancers) | <input type="checkbox"/> Abnormal Moles | <input type="checkbox"/> Psoriasis |

Other: _____

Allergies: _____

Current Medications (if choosing not to import from pharmacy):

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Feel free to use the back of this form if more space is needed)

Patient Social History- Please circle one response for each *required* question:

Alcohol: None <1 drinks/day 1-2 drinks/day >3 drinks/day

Tobacco: Never Smoker Current Smoker Former Smoker