NATURAL STATE
DERMATOLOGY

NEW PATIENT INFORMATION:

Full Name: _____ Preferred Name: _____
DOB: _____ Age: _____ Sex: _____ SSN: _____
Marital Status: _____ Language: _____

Please Circle:

Race: Caucasian African-American Hispanic Asian Other
Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Home Phone: _____
Preferred method of contact? Cell Home
Email: _____
Any restrictions on contacting you? Yes No
If yes, please explain: _____

Please provide your insurance card to the receptionist.

If the insurance policy holder is someone other than the patient, please fill out the information below:

Primary Insurance Policy Holder Name: _____
Primary Policy Holder's Date of Birth: _____
Primary Policy Holder's SSN: _____
Parent/Legal Guardian (if minor): _____
Relationship to Patient: _____ DOB: _____
Address (if different from above): _____
City: _____ State: _____ Zip Code: _____

I understand that office visit charges are payable on the day service is rendered. I authorize ***Natural State Dermatology*** *to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between* ***Natural State Dermatology*** *and myself.*

Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY

Name: _____ **DOB:** _____

Personal History (Please check all that apply):

____ Anxiety	____ Heart Disease	____ Psoriasis
____ Arthritis	____ Hepatitis	____ Skin Cancer
____ Asthma	____ High Blood Pressure	____ Cancer
____ Autoimmune Disease	____ Skin Disease	Type: _____
____ HIV	____ Stroke	____ Depression
____ Hives	____ Thyroid Disorder	____ Diabetes
____ Melanoma	____ Tuberculosis	____ Eczema
____ Pregnant	____ Ulcers	

____ Require antibiotics before teeth cleanings or surgeries

Past Surgeries/Hospitilizations:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Family History (Please check all that apply):

____ Acne	____ Melanoma	____ Skin Cancer
____ Diabetes	____ Thyroid Disorder	____ Eczema
____ Psoriasis	____ Vitiligo	____ Autoimmune Disease

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Allergies (Food, Drug, or Environmental):

_____

_____

_____

Primary Care Physician: _____

Preferred Pharmacy: _____

Street/City/State: _____

Current Medications:

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: 0 drinks/day <1-4 drinks/day 1-4 drinks/day >4 drinks/day

Tobacco: Never Smoker Current Smoker Previous Smoker

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

Name: _____

Relationship to Patient: _____

Phone Number: _____

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DESIGNATION OF PERSONAL REPRESENTATIVE
(FOR USE AND DISCLOSURE OF HEALTH INFORMATION ONLY)

The Health Information Portability and Accountability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you and your care. This form indicates your desire to designate the listed individual(s) to be your personal representative for your health information. Your designation can be revoked at any time.

____ I understand, and hereby authorize the following person(s) to act as my personal representative with respect to decisions regarding the use and/or to act as my personal representative with respect to decisions regarding the use and/or disclosure of my health information. **You may discuss my medical care with:**

_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship

I understand that I may revoke this designation at any time by submitting a change in writing.

____ I do not wish to assign a personal representative. (**Do not discuss my medical care with anyone but me.)**

Acknowledgement of Notice of Privacy Practices

This notice states how we use and/or disclose your health information and is available upon request.

_____	_____	_____
Name (Please Print)	**Signature**	**Date**

NATURAL STATE
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FINANCIAL AGREEMENT

Thank you for choosing Natural State Dermatology as your health care provider. The following is a statement of our financial policy in which we require that you read and sign prior to any treatment or office visit:

1. **Deductibles, copays, and any uncovered services are due at the time of service.**
2. **Fifty percent (50%) of the balance is due if a payment plan is requested.**
3. **You will be considered self pay until a copy of your insurance card and referral (if required) is provided.**
4. **We accept cash, checks, and credit cards.**
5. **As a courtesy, we will file your primary and secondary insurance claims when supplied with the current insurance information.**
6. **Medicare- We accept assignment. You will be responsible for the deductible and/or 20% co-insurance if not covered by your supplemental policy.**
7. **HMOs/PPOs- Please bring your referral number and your copay when you come for an office visit. These are the rules of your HMO Plan. (It is the patient's responsibility to get referrals for visits).**
8. **Minor- The adult accompanying the minor will be responsible for payment at the time of service.**

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.

_____ _____ _____

Patient's Signature **Office Staff Signature** **Date**

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