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. A $25.00 No-Show or Cancellation fee will be charged in the absence of 24-hour notice.

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): _____

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PATIENT MEDICAL HISTORY

Name: _____ **DOB:** _____

What are you needing to be seen for today? _____

_____

Personal History (Please check all that apply):

____ Anxiety	____ Stroke	____ Hearing Loss
____ Arthritis	____ Depression	____ Cancer: _____
____ Asthma	____ Diabetes	____ Tuberculosis
____ Heart Disease	____ High Blood Pressure	____ HIV

Other: _____

Past Surgeries/Hospitilizations:

1. _____
2. _____
3. _____

Skin History (Please check all that apply):

____ Acne	____ Skin Cancer: _____	____ Eczema
____ AKs (Pre-Cancers)	____ Abnormal Moles	____ 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