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Patient Registration

GENERAL INFORMATION

Patient's Legal Name *(as it appear as on Driver's Licence or Photo ID)*

Last Name: ______________ First Name: ______________ Middle initial: ______

Social Security Number: ______________ Patient Date of Birth (MM/DD/YYYY): ______________

Birth Sex: ______________ Preferred Language: ______________

Race: ______________ Ethnic Group: ______________

Marital Status: ______________ Drivers license number: ______________

CONTACT INFORMATION

Preferred Contact method: ❑ Phone ❑ Letter

Emergency Contact Name: ______________ Phone: ______________

Spouse Full Name: ______________ Phone: ______________

Caretaker Full Name: ______________ Phone: ______________

Patient Phone: ______________ (Home) ______________ (Work) ______________ (Mobile)

Preferred Phone: ❑ Home ❑ Work ❑ Mobile Is it OK to leave a detailed message? ❑ Yes ❑ No

Email Address: ______________

Would you like to opt in to email notifications? ❑ Yes ❑ No

MAILING ADDRESS

Street: ______________

City: ______________ State: ______________ Zip: ______________

EMPLOYER INFORMATION

Employer's Name: ____________________

Employer Phone: ____________________ Occupation: ____________________

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Patient's Relationship to Guarantor: ❑ Self ❑ Spouse ❑ Child ❑ Other ❑ Employee

Guarantor Last Name: ____________________ Guarantor First Name: ____________________

Guarantor Date of Birth: ____________________ Guarantor SSN: ____________________

❑ Guarantor Address is same as patient

❑ Guarantor Address if different:

Street: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Guarantor Phone: ____________________ Guarantor Email: ____________________

AUTHORIZATION

Authorization to Disclose Protected Health Information–I authorize the individual below access to my Protected Health Information.

Last Name: ____________________ First Name: ____________________

Home Phone: ____________________ Mobile Phone: ____________________

Relationship to the patient: ❑ Spouse ❑ Parent ❑ Child ❑ Friend ❑ Other

INSURANCE INFORMATION

PRIMARY Insurance Company: ______

Plan Name: ______ Policy Number: ______

Group Number: ______ Policy Type: ______

Last Name on Insurance Card: ______

First Name of Insurance Card: ______ Middle Initial: ______

Patient's Relationship to Policy Holder: ______

Specialist Co-Pay amount: ______
Please call insurance if unknown

Deductible: ______
Please call insurance if unknown

SECONDARY INSURANCE INFORMATION

SECONDARY Insurance Company: ______

Plan Name: ______ Policy Number: ______

Group Number: ______ Policy Type: ______

Last Name on Insurance Card: ______

First Name of Insurance Card: ______ Middle Initial: ______

Patient's Relationship to Policy Holder: ______

Specialist Co-Pay amount: ______
Please call insurance if unknown

Deductible: ______
Please call insurance if unknown

PHARMACY INFORMATION

Preferred Pharmacy Name *(list address or cross roads)*: ______

Pharmacy Phone: ______

PRIMARY CARE PHYSCIAN INFORMATION

Primary Care Physician(PCP): ____________________

PCP Phone: ____________________

REFERRED TO CLINIC BY:

Dr. ____________________ Phone Number: ____________________

❑ Family/friend ❑ Insurance ❑ Web search ❑ Print ad ❑ Other ad

I acknowledge this is information is accurate and complete and understand this information will be part of my medical record.

____________________ ____________________

Signature of patient or authorized representative Date

Below: For Office Staff Only

❑ New or ❑ Established Patient

Portal setting enabled: ❑ Yes ❑ No

Patient representative account enabled: ❑ Yes ❑ No ❑ N/A

Username: ____________________

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Medical History

Please Mark/Circle the following Positive Medical History

PAST MEDICAL HISTORY

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ BPH
- ❑ CVA/Stroke
- ❑ COPD/Emphysema
- ❑ CAD (coronary artery disease)
- ❑ Depression
- ❑ Diabetes
- ❑ Elevated Blood Pressure
- ❑ End Stage Renal Disease
- ❑ Epilepsy
- ❑ GERD (reflux)
- ❑ Hearing loss
- ❑ HIV/AIDs
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism (high thyroid)
- ❑ Hypothyroidism (low thyroid)
- ❑ Hepatitis
- ❑ Leukemia
- ❑ Lymphoma
- ❑ Lung Cancer
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ Prostate Cancer
- ❑ Radiation treatment
- ❑ Bone Marrow transplant
- ❑ Autoimmune disease
- ❑ Other

SKIN DISEASE

- ❑ Acne
- ❑ Actinic keratosis
- ❑ Asteatosis (Excessive Dry Skin)
- ❑ Basal cell carcinoma
- ❑ Dysplastic nevi (Precancerous moles/Atypical Moles)
- ❑ Eczema
- ❑ History of Asthma
- ❑ History of Hay Fever
- ❑ Melanoma
- ❑ Pruritus (Itchy) Scalp
- ❑ Psoriasis
- ❑ Squamous cell carcinoma
- ❑ Sunburn of Second degree
- ❑ Autoimmune skin rashes/disease
- ❑ Other

PAST SURGICAL HISTORY

Please note any past surgeries: ______________________________

____

OTHER QUESTIONS

Do you wear sunscreen? ❑ Yes ❑ No If yes, what SPF: ______________

Do you tan in a salon? ❑ Yes ❑ No

FAMILY HISTORY

Do you have a family history melanoma? ❑ Yes ❑ No

If yes, which relative? ______________________________

MEDICATIONS

Please list all medications and supplements you take – *please include the dose, and how many times taken daily – If needed, attach a separate sheet*

ALLERGIES

Please list allergies with reactions:

SOCIAL HISTORY

Smoking status: ❑ Non Smoker ❑ Former Smoker ❑ Current Smoker ❑ Other Tobacco

If you currently smoke, how much per day? ____________________

ALCOHOL HISTORY

Do you drink alcohol? ❑ Yes ❑ No

If yes, do you drink: ❑ <1 drink per day ❑ 1–2 drinks per day ❑ >3 drinks per day

OCCUPATION

What is your occupation and workplace? ____________________

If retired, what is your past occupation? ____________________

REVIEW OF SYSTEMS

Do you have problems with: ❑ healing ❑ scarring OR ❑ bleeding?

ALERTS: Please Mark the following

❑ Allergy to lidocaine
❑ Allergy to topical antibiotics
❑ Allergy to latex
❑ Artificial heart valve
❑ Artificial joints placed within the past 2 years
❑ Currently on blood thinner
  ❑ If so, what type ____________
❑ Defibrillator

❑ Pacemaker
❑ History of MRSA infection
❑ Premedication to procedures
❑ Rapid Heartbeat with epinephrine
❑ Currently pregnant or planning to get pregnant in the near future
❑ HIV/AIDs
❑ Hepatitis C

DERMATOLOGY
OF NEW MEXICO

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Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient name: ______________________________

Date: ______________________________

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that I have certain Patient Rights regarding my protected health information.

I understand that Dermatology of New Mexico, LLC may use or disclose my protected health information for treatment, payment, or health care related operations which includes providing health care to me, the patient, handling billing and payment; and/or taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Dermatology of New Mexico, LLC has a detailed document called the: Notice of Privacy Practices, which contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the Notice of Privacy Practices before signing this agreement.

If I ask, Dermatology of New Mexico, LLC will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review this copy of the Notice of Privacy Practices.

My signature means that I agree to allow Dermatology of New Mexico, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Dermatology of New Mexico, LLC has taken action relying on this consent.

______________________________ ______________
Signature (Patient or Legal Custodian/Authorized Representative) Date

______________________________ ______________
Relationship to Patient if signed by another party Date

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Dermatology of New Mexico 610 Broadway BLVD NE, Albuquerque, New Mexico, 87102
Phone: 505.225.2500 Fax: 505.225.2025

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Policy on Release of Protected Health Information to Family Members or Friends

Patient name: ______________________________

Patient Date of Birth: ______________________________

It is the office policy of Dermatology of New Mexico, LLC not to release Protected Health Information to family members or friends, except for parent/legal guardian, or other persons authorized by the patient.

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers please name those individuals below. Your Protected Health Information including diagnosis/results or treatment may be given to these individuals in the event we cannot reach you or if you ask us to do so.

If you do not want any of your medical information provided to any other person please check the box below.

❑ NO, I do not authorize my Protected Health Information to be release to any other individual

By signing below, you authorize the following people to receive information regarding your Protected Health Information which may include diagnosis/results and treatment.

______________________________ ______________
Signature Date

LIST MEMBERS OR FRIENDS

Name: ______________________________

Phone Number: ______________ Relationship to patient: ______________

Name: ______________________________

Phone Number: ______________ Relationship to patient: ______________