



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: _____ Deductible: _____

Please call insurance if unknown

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: _____ Deductible: _____

Please call insurance if unknown

Please call insurance if unknown

PHARMACY INFORMATION

Preferred Pharmacy Name (list address or cross roads): _____

Pharmacy Phone: _____

PRIMARY CARE PHYSICIAN 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 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: _____



Medical History

Please Mark/Circle the following Positive Medical History

PAST MEDICAL HISTORY

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

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

- | | |
|---|--|
| <input type="checkbox"/> Allergy to lidocaine | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to topical antibiotics | <input type="checkbox"/> History of MRSA infection |
| <input type="checkbox"/> Allergy to latex | <input type="checkbox"/> Premedication to procedures |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Rapid Heartbeat with epinephrine |
| <input type="checkbox"/> Artificial joints placed within the past 2 years | <input type="checkbox"/> Currently pregnant or planning to get pregnant in the near future |
| <input type="checkbox"/> Currently on blood thinner | <input type="checkbox"/> HIV/AIDs |
| <input type="checkbox"/> If so, what type _____ | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Defibrillator | |



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



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: _____



Assignment of Insurance Benefits and Policies of Dermatology of New Mexico, LLC

Assignment of Insurance Benefits: I request that payment of authorized benefits be made on my behalf to Dermatology of New Mexico, LLC for any services furnished. I understand that I am financially responsible for any balance. I authorize Dermatology of New Mexico to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my insurance carrier and its agents will not direct payment to Dermatology of New Mexico, I agree to forward to Dermatology of New Mexico all health insurance payments, which I receive for the services rendered. I authorize Dermatology of New Mexico to release to the insurance carrier and its agents any medical information needed to process claims. I acknowledge that this authorization will be valid for all subsequent visits unless cancelled in writing by me or an authorized agent.

I designate Dermatology of New Mexico as an authorized representative to act on my behalf in regard to claims submitted to any employee health plan or other source of Third-Party Coverage for Services rendered by Dermatology of New Mexico. This designation includes, but is not limited to, initial determinations, requests for documents, requests for additional information and appeals.

Laboratory and Pathology Services

Please note: any outgoing pathology not read in the office will be submitted to TriCore Laboratories unless otherwise specified by the patient. I understand that any laboratory charges for pathology or laboratory services cannot be predetermined by Dermatology of New Mexico and are billed separately by the laboratory to the patient's insurance.

Notice of Privacy Practices: I have read or been offered a copy of Dermatology of New Mexico's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and to bill on my behalf. I understand I am entitled to a copy of the Notice of Privacy Practices. I authorize photos of myself related to my medical history be stored in my medical record.

Payment Policy: Payment is due at the time of service, including copays and any prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Dermatology of New Mexico.

Consent for Communication: I understand Dermatology of New Mexico may send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.

Patient Rights: I have read or been offered a copy of Dermatology of New Mexico Patient Rights.

Missed, No Show or Cancelled Appointment Policy: As a courtesy to other patients waiting to be seen by Dermatology of New Mexico we have the following policy on missed appointments. We require a 24-hour cancellation notice if you are not able to keep your regularly scheduled clinic appointment. If you do not cancel prior to this time you will be charged \$100.00 for new patient appointments and \$50.00 for any established patient appointments. We require a 48-hour cancellation notice if you are not able to keep your surgical, cosmetic or specially reserved appointments. If you do not cancel prior to this time, you will be charged \$100.00. We require 48-hour cancellation notice for any esthetic services. If you do not cancel prior to this time, you will be charged \$50.00.

We appreciate your understanding of this policy as missed appointments prevent other patients from seeing our providers in a timely fashion.

Late Arrival Policy:

1) For the first visit to Dermatology of New Mexico, we suggest patients arrive 30 -45 minutes before their appointment to complete the registration paperwork.

2) On Follow up visits, patients should arrive 15 minutes before their appointment.

3) Surgical patients should arrive 30 minutes prior to their appointment.

If you are more than 15 minutes late from your appointment you may have to reschedule your appointment. If you are running late please notify the clinic so we may advise you appropriately.

Authorizations: I authorize medical treatment of the person named below and agree to pay all fees and charges for such treatment. I understand that medical treatment may include a review of medical history, discussion of reason for visit and medical photographs of the area being discussed. I authorize Dermatology of New Mexico to disclose complete information concerning medical findings and treatment of the undersigned, to those individuals who, in Dermatology of New Mexico's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Dermatology of New Mexico, LLC.

Thank you,

Patient name

Date

Patient Signature

Guardian Name

Date

Guardian Signature