DERMATOLOGY
OF NEW MEXICO

P: 505.225.2500 | **F:** 505.225.2025
610 Broadway Blvd. N.E. , Albuquerque, NM 87102
dermatologynm.com

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: _____

Last 4 of 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 ❑ Email

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: _____

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 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

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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

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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, treatment and appointment reminders.

_____ _____
Signature Date

LIST FAMILY MEMBERS OR FRIENDS

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to patient: _____

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to patient: _____

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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