Patient Personal Information

Patient Full Name:

Date of Birth: ❑ Male ❑ Female

Social Security Number (optional):

Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Home Address:

City: State: Zip:

Mailing address:

City: State: Zip:

Employer:

Address:

ID/Driver's License #: E-Mail:

Ethnicity: Are you Hispanic/Latino? ❑ Yes ❑ No | ❑ Decline to State

Race: ❑Caucasian (White) ❑Asian ❑Native Hawaiian ❑African American

❑American Indian or Alaskan Native ❑Decline to State

Preferred Language:

Preferred Pharmacy Name:

Preferred Pharmacy City: Street:

Patient Contact Information

Cell #: Home #: Work #:

Which is the best number to reach you ? ❑ Cell ❑ Home ❑ Work

Preferred Appt Reminder Method? ❑ Text ❑ Email Phone Call: ❑ Cell ❑ Home

In case of emergency who should we contact?

Name: Relationship:

Work #: Home #: Cell #:

Address:

City: State: Zip:

Primary Insurance Information

Insurance Co:

Subscriber Name: Date of Birth:

Subscriber ID#:

Subscriber SSN:

Secondary Insurance Information

Insurance Co:

Subscriber Name: Date of Birth:

Subscriber ID#:

Subscriber SSN:

Tertiary Insurance Information

Insurance Co:

Subscriber Name: Date of Birth:

Subscriber ID#:

Subscriber SSN:

Physician Referral Information

Referred By:

Primary Care Physician:

Also under the care of MD(s):

Signature

Print Name:

Patient / Parent / Legal Guardian (please circle relationship)

Signature: Date:

NEW PATIENT HISTORY

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name: _____ First Name: _____ Age: _____

Reason for visit today: _____

Please indicate by checking the box if ***YOU*** have ever been diagnosed with any of the following:

- ☐ Cold Sores
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Kidney disease
- ☐ Psoriasis
- ☐ Eczema/atopic dermatitis
- ☐ HIV
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Heart disease
- ☐ Internal Cancer
  Type:_____
- ☐ Hepatitis
  if yes, circle all that apply
  B or C
- ☐ Chest pain/tightness or heart disease
- ☐ Keloids
- ☐ Artificial joints
- ☐ Artificial heart valve(s)
- ☐ Thyroid problem
  Hyper(high) / Hypo(low) *(circle one)*
- ☐ Lung problems/asthma
- ☐ Shortness of breath
- ☐ Hay fever or seasonal allergies
- ☐ Blood/circulation problem
  List specific problem:_____
- ☐ Epilepsy or seizures
- ☐ Mental/nervous disorder
- ☐ Blood Transfusion
- ☐ Sexually transmitted disease
  List types(s)_____

☐ Other, if not listed_____

Have ***YOU*** ever had any of the following skin cancers? (See below) If yes, please circle all that apply and provide details below:
Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Other: _____
If any circled above, please provide when it was treated and location on your body:

_____

_____

Please list any operations you have had within the past 5 years:

Year	Operation

Please indicate any hospital admissions or medical conditions not listed above: _____

_____

Please list all medications and supplements that you are currently taking

Medication/Supplement	Dosage and directions

Have you ever had any problems with local Anesthesia? YES OR NO *(Circle one)*
If yes, please give a brief explanation of what happened:

_____

MEDICATION ALLERGIES

Please List Below or check **NONE** ☐

Name of Medication	Type of Allergic Reaction

Is there a ***FAMILY HISTORY*** for any of the following skin cancers? (See below) If yes, please circle all that apply and provide details below:

Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Other: _____

If known, please indicate which family member: _____

Please indicate by the checking the box if there is a ***FAMILY HISTORY*** for any of the following:

- ☐ Internal Cancer Type:_____
- ☐ Hepatitis if yes, circle all that apply B or C
- ☐ Cold Sores
- ☐ Kidney disease
- ☐ Psoriasis
- ☐ Eczema/atopic dermatitis
- ☐ HIV
- ☐ Heart disease
- ☐ Keloids
- ☐ Thyroid problem
- ☐ Lung problems/asthma
- ☐ Hay fever or seasonal allergies
- ☐ Blood/circulation problem
- ☐ Epilepsy or seizures
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Other, if not listed: _____

Do you drink alcohol? Yes No

If yes, please describe how often (circle one): Everyday Some days Not often Social use only

Have you ever used any tobacco products? Yes Never

If yes, please describe how often (circle one): Everyday Some days Former smoker/tobacco user Social use only

Do you use any illegal drugs? Yes No

If yes, please describe type: _____

***Females Only*: Are you pregnant?** Yes No

If yes, when is your due date? _____/_____/_____

Occupation: _____

I certify the above information is true and accurate

Patient Signature (parent if patient is a minor): _____

Redwood Family Dermatology

ePrescribing consent

ePrescribing is a federally mandated initiative by the Center for Medicare and Medicaid Services (CMS) that requires all physicians prescribe in this manner.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software allows your physician to see important information, like drug interactions and your prescription history.

By signing the consent below, you will benefit from a safer, faster and easier way to get your prescriptions filled.

I agree that **Redwood Family Dermatology** may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient's Signature _____ Date _____
Signature of Patient or Responsible Party

Patient's Name (Please Print) _____
First Name Last Name

Expiration Date: Unlimited, unless otherwise indicated _____
Other date

Redwood Family Dermatology
Financial Policy

We are committed to providing you and your family with the best possible care. In order to achieve this, we ask for your cooperation with our Financial Policy. Please read over the details of this policy carefully.

- For uninsured patients, payment is expected at the time of service.
- A copy of your insurance card(s) and you ID will be made for your chart. Your copayment is due at the time of service.
- If your health plan requires a prior authorization to see a specialist, you are required to obtain the prior authorization before obtaining medical services with the specialist.
- Your insurance is a contract between you, your employer (if applicable) and your insurance company. You are responsible for payment of any deductible, copay or coinsurance your insurance applies to your claim.
- It is your responsibility to inform us of any changes in your insurance coverage.
- As a courtesy, we will submit a claim to your insurance on your behalf.
- Your health plan or Medicare may not cover some or all of the services provided. Services denied as not a covered benefit, deemed not medically necessary or deemed cosmetic by the insurance company are the responsibility of the patient.
- Payment for cosmetic products and/or cosmetic services is required to be paid in full at the time of service.
- Procedures done in our office are under the heading of "surgery" by all insurances companies. You likely will receive an explanation of benefits showing you had "surgery" with our office.
- Dermatology does not fall under "preventative services" by insurance companies as Dermatology visits are based on a diagnosed problem.
- There is a $25 charge for checks returned for non-sufficient funds.
- Timely payment of your balance is required. Your balance is due upon receipt of your statement.

Assignment of benefits:

I hereby give authorization for payment of Medicare/Health Plan befits to be made directly to Redwood Family Dermatology for services rendered. I authorize Redwood Family Dermatology to release all necessary information to secure befit payments. I agree a photocopy of this agreement shall be valid as the original.

_____ _____

Signature of Patient or Responsible Party Date

_____

Patients Name (Please print)

REDWOOD FAMILY DERMATOLOGY

PATIENT RECORD OF DISCLOSURES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided with the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Primary Telephone: _____

☐ O.K. to leave message with detailed information on answering machine

☐ Leave message with call back number only

Discuss your medical condition with any member of your home? ☐ YES ☐ NO

With whom may we discuss your medical condition? _____

Work Telephone:

☐ O.K to leave message with detailed information

☐ Leave message with call back number only

Written Communication:

☐ Mail to my home address

☐ Mail to my work/office address: _____

_____

☐ O.K. to fax to this number: _____

Please note, it is the patient's responsibility to inform our office of any change of information.

My signature below also acknowledges that I have received the Notice of Privacy Practices

_____ _____

Signature of Patient/Parent/Legal Guardian/Personal Representative (Please Circle) Print Patient's Name

_____ _____

Print Your Name Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosure made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosure. (Note: Uses and disclosures for treatment, payment or operations (TPO) are permitted without consent.)

Record of Disclosures of Protected Health Information

Date	Disclosed to whom (address or fax)	Authorized in writing	Description of disclosure	Disclosed by whom	Reason	How disclosed*

*Fax, Telephone, E-Mail, Mail or Other