ARBORETUM DERMATOLOGY

Patient Information

Name _____

Responsible Party _____

Address _____ City/St/Zip _____

Telephone Number: Home _____ Work _____ Cell _____
SS# _____ Age _____ Date of Birth _____ Male □ Female □
Minor □ Single □ Married □ Divorced □ Widow □ Separated □
Referred by _____
Employer _____ Occupation _____
Spouse _____ Employer _____

Medicare # _____

Primary Insurance Co. _____
Address _____
Insured Name _____ Date of Birth _____
Social Security# _____ ID# _____
Group Name or # _____
Relationship to Patient: Self □ Other _____

Secondary Insurance Co. _____
Address _____
Insured Name _____ Date of Birth _____
Social Security# _____ ID# _____
Group Name or # _____
Relationship to Patient: Self □ Other _____

Arboretum Dermatology's Notice of Privacy Practices has been made available to me for review. I hereby authorize Arboretum Dermatology to furnish information to my insurance company concerning my diagnoses and treatment and assign to Arboretum Dermatology all payments for medical services rendered.

Signature of Patient or Guardian _____ Date _____

Payment will be made by: Cash □ Check □ MC/VISA □

Referring Physician/Clinic: Name: _____

Address: _____

City _____ State _____ Zip _____

Referring Physician Specialty: _____

Date: _____

Occupation: _____

Tel. #:

Home: _____ Work: _____

HEALTH QUESTIONNAIRE

(Please explain all "yes" answers)

1. Do you have any allergies to medications? ☐ No ☐ Yes Please explain: _____

Do you have any unusual reactions to medications or injections (such as fainting)? ☐ No ☐ Yes Please explain: _____

2. Do you take any medications? ☐ No ☐ Yes Please explain: _____

Do you take any vitamins/health food supplements? ☐ No ☐ Yes Please explain: _____

Are you on a special diet? ☐ No ☐ Yes Please explain: _____

3. Have you seen another doctor for your current skin problem? ☐ No ☐ Yes Please explain: _____

4. What medications or other creams do you apply to your skin? _____

5. Do you have any chronic or recurring problems with:

☐ nerves	☐ stomach	☐ bones or joints
☐ eyes	☐ bowel movements	☐ breathing (asthma, hay fever, others)
☐ hearing	☐ heart	☐ glands (thyroid, diabetes, other)
☐ sinuses	☐ blood pressure	☐ kidneys or bladder
☐ mouth	☐ circulation	☐ liver
☐ artificial body parts (e.g., heart valves)	☐ bleeding, blood disorders	☐ infections

If yes, please explain: _____

6. Do you take antibiotics when you go to the dentist for teeth cleaning? ☐ No ☐ Yes Please explain: _____

7. Have you been under a doctor's care or hospitalized in the past five years? Please explain: _____

8. Do you or any relative have diabetes, cancer, asthma, hay fever, eczema, or other problems? Please explain: _____

9. For women: Are you pregnant, trying to conceive, or breast feeding a child? _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I am confirming that I have been informed of my rights to privacy regarding my Protected Health Information (PHI) to carry out treatment, payment, and healthcare operations (TPO) under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.**
- **Process insurance claims, insurance applications and prescriptions.**
- **Conduct normal health care operations such as quality assessment and improvement activities.**

I have been informed of my medical's provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my Protected Health Information (PHI). I have been given the right to review and option to receive a copy of such notice. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice Of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used if disclosed to carry out Treatment, Payment, and Healthcare Operations (TPO), and I understand that you are not required to agree to my requested restriction, but if you do agree than you are bound to abide by such restrictions.

Signing this consent form is required in order to receive the most efficient treatment available at ARBORETUM DERMATOLOGY.

With this consent, ARBORETUM DERMATOLOGY may call my home or designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out the TPO, such as appointment reminders, insurance items, calls pertaining to my clinical care including laboratory and pathology results among others.

_____

Patient Name **Patient/Authorized Signature**

_____

Relationship to Patient **Date**

Please list any persons to whom your Protected Health Information can be disclosed.

Primary Physician: _____

Address/Practice: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____