Paladin Dermatology

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____

DOB: _____ Sex: ____ Marital Status: _____ Social Security #:_____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Please Circle Preferred Method of Contact

Home Phone: _____Cell Phone: _____Work Phone: _____

Employer / School: _____ E-Mail: _____

Primary Care Physician: _____ Phone: _____

RESPONSIBLE PARTY (Please complete if patient is under the age of 18)

Relationship to Patient: _____ Name: _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

DOB: _____ SSN: _____ Employer: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

Address, City, State, Zip: _____

How did you hear about Paladin Dermatology

Physician Referral _____ Word of Mouth _____ Internet _____ Newspaper / Magazine _____
Drove by our Clinic _____ Health Fair _____ Direct mail _____ Insurance Co _____ Other _____

PHOTOGRAPHS

I authorize Paladin Dermatology to take photos that may be requested during treatment. Any photograph taken will be used for treatment and educational purposes with the appropriate privacy.

☐ YES ☐ NO

FINANCIAL POLICY

I have read and understand the terms of the Paladin Dermatology Financial Policy. I have also been offered a copy of this financial policy.

_____ _____
Signature of Patient / Guardian Date

Paladin Dermatology

****PLEASE NOTE****

We are glad to file insurance for you and will do so in a timely manner. However, to do so, the following information needs to be given in its entirety. Incomplete information will result in us not being able to file your insurance claim and you will be given the option to either pay in full for services rendered on the day of your visit or to reschedule your appointment.

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Primary Cardholder's Name: _____ DOB: _____

Relationship to Patient: ___ Self ____Spouse ____ Dependent

Secondary Insurance: _____ Policy #: _____ Group#: _____

Secondary Cardholder Name: _____ DOB: _____

Secondary Cardholder Relationship to Patient: ___ Self ____Spouse ____ Dependent

If Separate Rx Plan:

Rx Plan Name: _____ Phone: _____

Rx Plan ID Number: _____

Authorization for Release of Information

Release of Medical Information

Do we have your permission to discuss any medical condition or treatments, and/or leave a message with a family member/ member of your household /friend/other? _____ **YES (Please List)** _____ **NO**

NAME: _____ Relationship: _____ Phone: _____

☐ Results of Lab/Other Tests ☐ Financial information ☐ Other information: _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I hereby give my consent for Paladin Dermatology to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations. I have received and read the **NOTICE OF PRIVACY PRACTICES** prior to signing this consent.

_____ _____

Patient Signature **Date.**

Patient Name: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

PATIENT HISTORY

Do you have or have you ever had the following (please circle):

HIV/AIDS	Defibrillator	Anxiety	Hearing Loss	Hepatitis B or C
Pacemaker	Arthritis	Asthma	Tuberculosis	High Blood Pressure
Diabetes	Depression	Kidney Disease	Liver Disease	Mitral Valve Prolapse
Inflammatory Bowel Disease		Coronary Artery Disease		Hyper-/Hypo- Thyroidism

Internal Cancer of: _____ Other: _____

Past Surgical History (please circle):

Appendix	Coronary Artery Bypass Surgery	Joint Replacement: Knee Hip Shoulder
Tonsils	Heart Valve Replacement	Organ Transplant: Heart Kidney Liver
Cancer	Hysterectomy	Other: _____
Colon Resection	Gallbladder (Cholecystectomy)	_____

Medications (please list): _____

_____

_____

_____

Do you take any blood thinners: None Aspirin Coumadin Plavix Other: _____

Medication allergies: _____

Other allergies (please circle): Latex Tape Neosporin Other: _____

Have you ever been Diagnosed with Psoriasis? Yes No **Eczema?** Yes No

Have you ever had skin cancer: Yes No If Yes, what type: _____

Please list any blood relatives with a history of skin cancer (Melanoma):_____ **Type:** _____

Do you use tobacco products: Never Yes Quit **Breastfeeding**: Yes No

Are you Pregnant: Yes No **Do you drink alcohol**: Yes No

Have you ever received the Pneumonia Vaccine? Yes No

Have you received the Flu Vaccine this year? Yes No

Paladin Dermatology

Authorization for Release of Information – Compound Release

Patient Name:

Patient Date of Birth:

The office of Paladin Dermatology is authorized to release protected health information as described below for the identified patient.

Entity to Receive Information. Check each person or class of persons that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐**Voice Messages on _____ number.**	☐**Appointment Reminders** ☐**Lab Results** ☐**Other**
☐**Spouse or Significant Other:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing, or on the date listed below:

_____

Signature of Patient or Personal Representative Date:

Description of Personal Representative's Authority (attach necessary documentation) :

☐ Mother ☐ Father ☐ Legal Guardian

Date this Authorization Expires: _____

Acknowledgement of Receipt of Notice of Privacy Practices
Paladin Dermatology

Patient Name & Address:

I have received a copy of the Notice of Privacy Practices.

Signature	Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

- ❑ Other:

Prepared by:	
Signature:	
Date:	

Paladin Dermatology

Authorization for Release of Information – Media

Patient Name:

Patient Date of Birth:

Paladin Dermatology is authorized to release protected health information as described below for the identified patient.

Use still, audio and video images with my likeness for the purposes of (Check all that Apply):

☐ **Facebook**

☐ **Instagram**

☐ **Twitter**

☐ **Practice Website**

☐ **Advertising**

☐ **Before and After Photos**

☐ **Posted/Streamed in Office**

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing, or on the date listed below:

_____Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation) :

☐ Mother ☐ Father ☐ Legal Guardian

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