

New Patient Information Form

Please present your insurance card/s and picture identification to the receptionist. In order to file your insurance you must present a current insurance card.

Patient Name: _____
Last First Middle Initial

Local Address: _____
Street or PO Box City Zip Code

Other Address: _____
Street or PO Box City/State Zip Code

Home Phone #: _____ Cell Phone #: _____ Sex: Male Female

Social Sec. # _____ Date of Birth: ____/____/____

Marital Status (circle): M D S W Spouse's Name: _____

Please list name of any person (in your household), who is a patient here and their relationship to you: _____

Who referred you, and/or How did you find our office today?: Physician (name/city) _____ Yellow Pages _____ Insurance Directory _____ Friend (list) _____ Internet _____

Occupation _____ Employed by: _____
If we may contact you at work, please list phone # _____

Who is your Family/Primary Care Physician? _____

For all patients under 18 Please list child's guardian? _____

If you're not the primary policy holder of your insurance (for example your insurance is through your parent or spouse's employer), please complete: Insurance Subscriber Name: _____ Social Sec. # _____ Subscriber's date of birth: ____/____/____ Relationship to patient: _____

It is our policy that payment for services is expected at the time of your visit today. To help expedite your visit today, the receptionist will collect your payment before you are seen. For your convenience we accept Master Card, Visa, Discover and American Express.

Medical Questionnaire

Patient Name: _____

Date: ___ / ___ / ___

Why are you coming in to see Dr. Possick today ?

Have you been seen by another dermatologist this year ?YES NO

If so please list: _____

Have you ever been treated for any of the following ? (circle one)

Duodenal or Peptic Ulcers.....	YES	NO
Tuberculosis or Lung Disease.....	YES	NO
Heart Disease.....	YES	NO
High Blood Pressure.....	YES	NO
Kidney Disease.....	YES	NO
Liver Disease.....	YES	NO
Mental Illness or Depression.....	YES	NO

Have you ever been treated for a cancer / malignancy? YES NO

If yes, please list type of cancer and date/s: _____

Have you ever been diagnosed with a serious illness or medical condition ? YES NO

If yes, please list : _____

Have you ever been treated with Therapeutic Radiology (X-Ray) Treatments to your skin for Acne or Skin Cancer ? YES NO

Have you or any immediate family been diagnosed with any of the following :

- Asthma (circle one) self family member
- Hay Fever self family member
- Hives self family member
- Eczema self family member
- Diabetes self family member

Are you allergic to any medications or local anesthetics ? YES NO

If yes please list: _____

Are you taking any medications ? YES NO

Please list and include all over the counter medications, laxatives, aspirin, vitamins and herbal supplements:

PATIENT RELEASE:

I certify the information that I have provided is correct. I hereby authorize the release of medical, psychiatric, drug/ alcohol abuse, HIV or AIDs information in my records to my doctor and/ or insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider, Sidney Possick, M.D., P.A.

X _____ Date: _____

FOR INSURANCE PATIENTS:

Under a new law we are required to have a separate signature on file for filing your insurance/s. 0.and payment policies of your carrier. By signing below I understand and agree to the above insurance billing policy of this office.

X _____ Date: _____

CONSENT FOR SKIN SURGURIES AND/OR PROCEDURES:

My signature on this form authorizes Dr. Possick to perform in office surgical procedure/s. I have been informed and I understand the nature of the procedure and why it is necessary. I have also been informed and I understand the risks inherent to the performance of any surgical procedure, such as, the formation of thick or otherwise objectionable scars. I realize that these, or other natural complications may result from the surgical procedure. I give my permission to have any tissue(s) removed during the procedure, be sent for histologic examination by an outside pathologist. I also understand the pathologist will bill separately for the examination of the tissue.

X _____ Date: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA):

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

WITH WHOM MAY WE DISCLOSE ANY OF YOUR MEDICAL INFORMATION?

(Future appointments, test results, medical status, etc.)

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

X _____ Date: _____

Witness: _____ Date: _____