Rio Grande Dermatology

Complete the following information – Please print clearly

PATIENT INFORMATION

Name:	Patient #:
Address:	Date of Birth: Sex:
City:	Social Security #:
State: Zip:	E-mail:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:
Primary Dr.:	Referring Dr.:
How did you hear about our office?	

RESPONSIBLE PARTY

Name:	Date of Birth:
Address:	Social Security#:
City:	
State: Zip:	Employer:
Home Phone#:	Employer Address:
Work Phone#:	City:
Cell Phone#:	State: Zip:

INSURANCE INFORMATION

First Insurance:	Second Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscr 1 Birthdate:	Subscr 2 Birthdate:

I would like a copy of the Notice of Privacy Practices ☐ **Yes** ☐ **No**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to Rio Grande Dermatology, PC when assignment is accepted and this office files claims for me. I understand that Co-Pays, Deductibles, and Co-Insurance payments may be requested of me at each visit and I will be prepared to make payment. If I file my claim personally, I understand payment must be made in full at the time of services; no discounts are applied to "self-filed" claims.

Authorization To Release Medical Information. I hereby authorize Rio Grande Dermatology, PC to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) Date

Demographic Questionnaire: **Patient Number** _____

Please select one of each of the following demographic topics. Please note that this information is confidential and voluntary. If you do not wish to participate please select "Refused to Report/Unreported".

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White/Caucasian
- ☐ Other Pacific Islander
- ☐ More than One Race
- ☐ Refuse to Report/Unreported

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to Report/Unreported

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Japanese

DERMATOLOGY MEDICAL HISTORY FORM

Patient's Name _____ **Date of Birth** _____ **Today's Date** _____

Reason for Today's Visit _____ **Duration of Condition** _____

Allergies:

- ☐ Adhesive Tape
- ☐ Latex
- ☐ Lidocaine/Novocaine
- ☐ Nickel
- ☐ Perfume
- ☐ Sunlight

Allergies to Medications:

_____

_____

_____

_____

Current Medications:
(oral, topical, & supplements)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History Review of Symptoms

Please check all that *currently* apply to you:

- ☐ Bruising
- ☐ Chills
- ☐ Depression
- ☐ Dry Eyes
- ☐ Dry Lips
- ☐ Fatigue
- ☐ Fever
- ☐ Hair Loss
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Nail Changes
- ☐ Nausea
- ☐ Night Sweats
- ☐ Nose Bleeds
- ☐ Pain
- ☐ Pruritus (itchiness)
- ☐ Sleep Problems
- ☐ Sore throat
- ☐ Swollen lymph nodes
- ☐ Systemic Malignancy (Cancer)
- ☐ Weight Changes
- ☐ Yeast infections

Female Patient's:

- ☐ Are you currently pregnant?
- ☐ Are you breastfeeding?

Past Medical History:

- ☐ Skin Cancer
  (Melanoma, Basal or Squamous Cell Carcinoma)
- ☐ Cancer
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Arthritis/joint pain/lupus/artificial joints
- ☐ Asthma/Wheezing/Allergies
- ☐ Cardiac Disease
- ☐ Blood Disorder
- ☐ Autoimmune Disease
- ☐ Lipid Disorder
- ☐ Musculoskeletal Problems
- ☐ Thyroid Disease
- ☐ Pacemaker/Implanted Device
- ☐ Other _____

_____

Family History:

- ☐ Any Dermatologic Conditions
- ☐ Skin Cancer

Social History:

- ☐ Do you use sunscreen?

Pharmacy Name:

_____

Address/Intersection:

_____

Referring Physician:

_____

Rio Grande Dermatology
4545 Alameda, Suite G
Albuquerque, NM 87113
Phone (505) 896-2900
Fax (505) 938-4198

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), I have certain Patient Rights regarding my protected health information.

I understand that Rio Grande Dermatology may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, 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.

Rio Grande Dermatology has a detailed document called the ***'Notice of Privacy Practices'***. It 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'* before signing this agreement. If I ask, Rio Grande Dermatology will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Rio Grande Dermatology 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 Rio Grande Dermatology 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: Rio Grande Dermatology, 4545 Alameda NE, Suite G, Albuquerque, NM 87113 Phone (505) 896-2900, Fax (505) 938-4198.

FORM Us