RIO GRANDE DERMATOLOGY

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient's Legal Name: *(as it appears on Driver's License or Photo ID)* **First:** _____ **M.I:** _____ **Last:** _____	**Patient Date of Birth: (MM/DD/YYYY)** **Social Security Number:** *(N/A if under 18yrs of age)* _____---_____---_____
Mailing Address: Street: _____ City, State, Zip: _____	**Patient Gender: (circle): Male | Female** **Home Phone Number:**
Email Address:	**Mobile Phone Number:**
Emergency Contact:	**Emergency Contact Phone:**
Primary Care Physician (Full Name):	**PCP Phone Number:**
Pharmacy: *(list address or crossroads)*	**Pharmacy Phone Number:**

Language:	**Race:**	**Ethnicity:**

RESPONSIBLE PARTY INFORMATION (Parent /Legal Guardian/P.O.A)

Guarantor on Account: *(full name)*	**Guarantor Phone Number:**	**Guarantor Relationship to Patient:**
Guarantor SSN: _____---_____---_____ **Guarantor Date of Birth:**	**Guarantor Address:** *(if different than patient)* Street: _____ City, State, Zip: _____	

INSURANCE INFORMATION

Primary Insurance Company:	**Policy/ID Number:**	**Group Number:**
Policyholder's Name:	**Policyholder's Date of Birth:**	**Relationship to Patient:**
Secondary Insurance Company:	**Policy/ID Number:**	**Group Number:**
Policyholder's Name:	**Policyholder's Date of Birth:**	**Relationship to Patient:**

LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Rio Grande Dermatology. I understand that I am financially responsible for any balance. I also authorize Rio Grande Dermatology to release medical information required to process claims. **Please note:** All pathology is submitted to TriCore Laboratories unless otherwise specified by patient. I understand that any laboratory charges for biopsies taken or surgical procedures cannot be predetermined by Rio Grande Dermatology and are billed separately by the laboratory. **Notice of Privacy Practices:** I have read or been offered a copy of Rio Grande Dermatology Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record. **Payment Policy:** Payment is due at time of service, including copays and any prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Rio Grande Dermatology.

SIGNATURE

Patient / Guardian Signature:	**Date**:

RIO GRANDE DERMATOLOGY

Medical History and Intake Form

Patient Name: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY: (check all that apply)

- ◯ **Allergies (Seasonal)**
- ◯ **Arthritis**
- ◯ **Asthma**
- ◯ **Auto Immune Disorder**
- ◯ **Coronary Heart Disease**
- ◯ **Diabetes**
- ◯ **Hepatitis**
- ◯ **Hypercholesterolemia**
- ◯ **Hypertension**
- ◯ **HIV/AIDS**
- ◯ **Liver Disease**
- ◯ **Lupus/ Rheumatoid Arthritis**
- ◯ **Organ Transplant**
- ◯ **Radiation Treatment**
- ◯ **Thyroid Disease**

Do you have a history of any Skin Disorders? *(Examples: acne, eczema, precancerous lesions/moles)* **Yes**_____ **No** _____ *If yes, which one(s):*

_____

_____

Do you have a history of Skin Cancer? *(Examples: basal cell, squamous cell, melanoma)* **Yes**_____ **No**_____ *If yes, which one(s), location, and year*:

_____

_____

Do you have a Family History of Melanoma? *(First degree relative(s) only)* **Yes** _____ **No**_____ *If yes, whom?*

_____

MEDICATIONS: *(write down all prescription medications, provide list, or if none mark N/A)*

_____

_____

_____

ALLERGIES: *(Please enter all allergies to medications, if none mark N/A)*

_____

_____

SOCIAL HISTORY: Do you smoke? **Yes**_____ **No**_____ If yes, how much/often? _____

Do you drink alcohol? **Yes**_____ **No**_____ If yes, how much/often? _____

REVIEW OF SYSTEMS: (check all that apply)

- ◯ **Problems with Bleeding**
- ◯ **Problems with Scarring/Keloids**
- ◯ **Problems with Healing**

ALERTS: (check all that apply)

- ◯ **Artificial Heart Valve**
- ◯ **Blood Thinners**
- ◯ **Defibrillator**
- ◯ **Pacemaker**
- ◯ **Pregnant or trying to become pregnant**
- ◯ **Breastfeeding**
- ◯ **Allergy to Lidocaine**
- ◯ **Allergy to Iodine**

***IF YOU ARE 65YRS OF AGE OR OLDER - please answer the following: ***

Have you received a pneumonia vaccination? **Yes**_____ **No**_____

Do you have a health care proxy in the event you are unable to make your own medical decisions? **Yes**_____ **No**_____

If yes, who: Designee Name: _____ Telephone Number: _____

Do you have a living will? **Yes**_____ **No**_____

If yes, which statement best reflects your wishes on advanced care recommendations?

- ◯ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ◯ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- ◯ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

RIO GRANDE DERMATOLOGY

Rio Grande Dermatology
4545 Alameda, Suite G
Albuquerque, NM 87113
Phone (505) 896-2900
Fax (505) 938-4199

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) 938-4199.

FORM Us