DERMATOLOGY FOR THE FAMILY

PATIENT INFORMATION - ALL ITEMS MUST BE FILLED IN COMPLETELY

Today's Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ Date of Birth: _____ Age: ____ Sex: M F Other

City, State, Zip: _____ **Circle One:** Single • Married • Widowed • Divorced • Domestic Partnership

Employed By: _____ Home Phone: _____

Occupation: _____ Cell Phone: _____

Referred By: _____ Work Phone: _____ Ext. _____

Email Address: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP _____ **PHONE NUMBER** _____

INSURANCE INFORMATION

Policy Holder's Name: _____ Relationship to Policy Holder: _____

Sex: M F Other Date of Birth: _____

Primary Insurance Co: _____ ID # _____ Group # _____

Secondary Insurance Co: _____ ID # _____ Group # _____

RACE
- American Indian/Alaskan Native
- Asian
- Black or African American
- Native Hawaiian/Other Pacific Islander
- White
- Unknown/Other

ETHNICITY
- Not Hispanic or Latino
- Hispanic or Latino

PREFERRED LANGUAGE
- English
- Spanish
- Other: _____

SMOKING STATUS
- Never Smoked
- Current Smoker
- Former Smoker

ALCOHOL STATUS
- Do not drink
- Drink socially
- One or more drinks daily

WE ALSO OFFER:

☐ **Botox** ☐ **Laser**

☐ **Fillers** ☐ **Peels**

☐ **Rejuvapen**

Check box if interested

HEIGHT _____ inches **WEIGHT** _____ lbs

COVID-19 VACCINE _____ **Yes** _____ **No**

DO YOU TAKE ANY MEDICATIONS, HERBAL SUPPLEMENTS, OR MULTIVITAMINS? ( ) No ( ) If Yes, please list name, dosage & frequency:

_____

_____

DRUG ALLERGIES No Yes (please circle or list): Aspirin, Codeine, Penicillin, Sulfa, Other: _____

CURRENT PROBLEM (please circle or describe your main problem):

Acne, Eczema, Psoriasis, Rosacea, Poison Ivy, Warts, Other: _____

DO YOU HAVE A HISTORY OF (please circle): AIDS, Arthritis, Asthma, Bleeding Problems, Cancer, C-diff, Colitis, Diabetes, Eczema, Excessive Sweating, Hay Fever, Heart Disease, Hepatitis B/C, Hidradenitis Suppurativa, High Blood Pressure, High Cholesterol, HIV, Irregular Periods, Kidney Disease, MRSA, Psoriasis, Rosacea, Thyroid Disorder, Tuberculosis, Ulcers, Warts **NONE**

YOUR PRIMARY CARE PHYSICIAN (PCP) _____

YOUR PHARMACY _____ **ADDRESS/TELEPHONE:** _____

1) **I authorize the release of any medical or other information necessary to process this claim. I also request payment of government (or other health insurance) benefits either to myself or to the party who accepts assignment.**
2) **Medication History Consent: I authorize consent to obtain my medication history from my pharmacy(s).**
3) **I authorize information regarding my care to be provided through text message or voicemail message on my cell, home or work phone, or emailed to me.**
4) **I understand that I am responsible for any balance not covered by insurance. A current credit card will be kept on file and will be automatically drafted for any outstanding balance for all members on your policy.**
5) **There will be a $50.00 charge for appointments cancelled or missed without 48 hours advance notice. Also, if you have 3 or more cancelled or missed appointments, we reserve the right to dismiss you from our practice.**

Patient or authorized person's signature: _____ Physician's Review _____

Dermatology for the Family

149 East Avenue, Suite 20, Norwalk, CT 06851
Tel. (203) 853–1874 Fax. (203) 831-0007

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT – HIPAA

Effective April 14, 2003
Patient Consent for Use and Disclosure of Protected Health Information

With my signature, I consent that Dermatology for the Family, hereinafter also referred to as "the practice" may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Dermatology for the Family's Notice of Privacy Practices for more complete descriptions of such uses and disclosure. I have read the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology for the Family reserves the right to review and update its Notice of Privacy Practices at anytime.

I consent that Dermatology for the Family may call my home, work, or cell phone, and if I am unavailable, they may leave a message either on my answering machine or with whoever answers the telephone. The information may include, but is not limited to any item that assists the practice in carrying out TPO, such as appointment reminders, insurance items, payment/balance reminders, laboratory results, and any call pertaining to my clinical care.

I consent that Dermatology for the Family may mail or email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient billing statements, and informational mailings.

I have the right to request that Dermatology for the Family restricts how it uses or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dermatology for the Family's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology for the Family may decline to provide treatment to me.

RED FLAGS RULE

Effective 11/1/2009
Protecting Against Identity Theft

It is the policy of Dermatology for the Family to follow all federal and state laws and reporting requirements regarding identity theft. Thus, pursuant to the existing HIPAA Security Rule, appropriate physical, administrative, and technical safeguards are in place to reasonably safeguard protected health information and sensitive information related to patient identity from any intentional or unintentional use or disclosure.

_____ _____

Signature of patient or legal guardian Print patient's name

_____ _____

Print name of legal guardian, if not patient Date

Copy of government issued photo identification received _____.

Revised on 5/5/2014

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As of December 1, 2022, we are requiring all patients to maintain a credit card *(unrestricted) on file due to the increase of patient deductibles and coinsurance. This information is kept secured for your protection.

CARD ON FILE AUTHORIZATION
FOR FUTURE AND PAST DUE BALANCES
Credit Card, Debit Card, HSA, HRA and FSA Cards Accepted

I authorize Dermatology for the Family to charge the portion of my bill that is my financial responsibility to the following Credit, Debit, HSA, HRA or FSA card:

Please circle: Amex Discover MasterCard Visa HSA FSA HRA

IMAGE

Billing address : _____

City, State, Zip code : _____

I (we) the undersigned, authorize and request Dermatology for the Family to charge my card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. If my credit card declines, I will provide a new credit card number. I understand that a copy of my credit card will be kept on file.

This authorization relates to all payments, current or past due that are not covered by my insurance company, for services provided to me or my family members by Dermatology for the Family.

This authorization will remain in effect while under the care of Dermatology for the Family.

Patient Name (Print) _____

Patient Signature
(or guardian if patient is under 18) _____
Date