NORTH COUNTY DERMATOLOGY CENTER

New Patient Intake Form

PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Date of Birth _____ **Gender** ☐ Male ☐ Female **Marital Status:** _____

Address _____
Street City State Zip

Home: (____)_____-_____ **Work:** (____) _____-_____ **Cell:** (____) _____-_____

SSN: _____ **e-Mail :** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance: _____

ID: _____ Group #: _____

Subscriber Name: _____ DOB: _____ Relation: _____

Secondary Insurance: _____

ID: _____ Group #: _____

Subscriber Name: _____ DOB: _____ Relation: _____

GUARANTOR INFORMATION - (Applies to Minors only)

Name: _____ DOB: _____ Relation: _____

Address: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

These questions are included to comply with new Federal Health guidelines - we are required to ask for this information.

Ethnicity (check one)
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unspecified/Declined

Race (check one)
☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Island
☐ Black/African American ☐ White ☐ Declined or Unspecified

Preferred Language (check one)
☐ English ☐ Other: ☐ Declined or Unspecified

PATIENT CONSENT/FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF PRIVACY PRACTICES

1. By signing this form, I acknowledge that I have received and reviewed the NOTICE OF PRIVACY PRACTICES which states how my health care providers may use and disclose protected health information (PHI). The NOTICE OF PRIVACY PRACTICES is available for my review at www.northcountyderm.com and the reception desk of the office.

2. I agree that telephone messages regarding my appointments, prescriptions, laboratory/pathology results and all other PHI may be left for me on my home and mobile phone voicemail.

___ Detailed Message ___ Message left requesting to contact office

3. I agree that information about my appointments, prescriptions, laboratory/pathology results and all other PHI may be shared with my spouse, referring providers and consulting physicians unless specifically noted below.
_____
_____

4. I agree that information about my appointments, prescriptions, laboratory/pathology results and all other PHI may be shared with the following individuals (please include phone number):

Name: _____ Phone:_____

Name: _____ Phone:_____

5. I understand that I can change any of the authorizations in this agreement at any time by giving written notice to North County Dermatology Center (attn: HIPAA Compliance Officer).
6. I authorize the sharing of information about my appointments, prescriptions, laboratory/pathology results and all other PHI with my health insurance and benefits companies as well as my credit card companies in order to collect payment for services rendered.

7. I am aware that any office visit co-payments set by my insurance, are due and payable to my physician at the time services are rendered tome. I also understand that I am personally responsible for all charges incurred during the course of the examination/treatment deemed my responsibility by my insurance.

8. I authorize that North County Dermatology Center may contact me at the email address I provided elsewhere with information about my appointments, prescriptions, laboratory/pathology results and all other PHI.

9. **Third Party Financing Available:** We offer third party financing through Care Credit for services over $200.00 (6 months no interest with pay deferred interest)

10. **Self Pay Patients:** I understand that payment is due at time of service unless other payment arrangements have been made in advance of treatment.

Patient Signature: _____ Date:_____

Patient Name: _____ Relation to patient: _____

(Applies to minors only)

If Completing for a minor/child

I _____ am the parent, guardian or personal representative of _____. I acknowledge that payment is due at time of service. I understand that I am responsible for all fees and services rendered for treatment for my son/daughter.

NORTH COUNTY DERMATOLOGY CENTER

Health History Form

Date: _____

Patient Name: _____

PAST MEDICAL HISTORY: (Please list all medical conditions which you take medication for.)

1.	4.
2.	5.
3.	6.

SURGICALHISTORY: If yes, complete below. ☐ No Surgeries ☐ No Hospitalizations

Surgery	Surgery
1.	4.
2.	5.
3.	6.

SKIN DISEASE HISTORY: (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Other:_____
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Preferred Pharmacy: _____ **Phone:** _____

Pharmacy City: _____

FAMILY HISTORY: (Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	Yes / No	Relation to Patient
Melanoma		
Alopecia (hair loss)		
Psoriasis		
Auto Immune Disease		
High Blood Pressure		
Other:		

CURRENT MEDICATIONS: (Include Vitamins, Supplements, and over-the-counter medications)

☐ No Current Medications

Drug Name and Dosage	Drug Name and Dosage
1.	4.
2.	5.
3.	6.

ALLERGIES: If yes, complete below. ☐ No Known Medication Allergies

Name of Medication and Reaction	Name of Medication and Reaction
1.	4.
2.	5.
3.	6.

SMOKING STATUS (check one)

☐ Never been a smoker ☐ Former smoker ☐ Current smoker: sometimes ☐ Current smoker: everyday

SOCIAL HISTORY

Alcohol ☐ Yes ☐ No Quantity: _____

Do you have a Power of Attorney? ☐ Yes ☐ No

If yes, is it Active or for an Emergency Only? _____

Do you have an Advance Directive? ☐ Yes ☐ No

If yes, designee name/relationship _____

Have you had your flu shot this year? Yes No When_____

Have you had your pneumonia shot? Yes No When_____

ADDITIONAL INFORMATION

Any other information you wish to convey to your physician: _____

_____

Form Completed By:

_____ _____ _____

Name of Individual/Patient/Parent (Printed) Signature Date