PLEASE PRINT

Patient's Name ____

Address ____

City/State/Zip____

Billing address if different than above ______________________________

Date of Birth _____/_____/_____ Social Security Number _________-________-_________

Sex ________ Marital Status: ____single ____married ____widowed ____other

Phone: Home(______) ____________ Cell (______)__________ Work(_____) ____________

Email address ____

Patient's Employer ______________________ Employer phone ______________

If minor, name of Legal Guardian ______________________________

IN CASE OF EMERGENCY NOTIFY ____________________ PHONE______________

Primary Care Physician(name) ________________ Referred By________________
Address ______________________________ Phone # ________________

Please present insurance card(s) and photo ID to the receptionist so copies may be made

Primary Insurance ____
Name of Primary Insurance Holder______________________________________
Primary Insurance Holder: Date of Birth ____/____/____ Social Security _______-_______-_______

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required from you at the time of service for "your part" of the charges.

Preference for balance billing: ______ email _____ us mail _____ credit card on file

I give permission to the doctor and staff to leave a message on my answering machine ___ Y ___N
I give permission to the doctor and staff to call me at work ___Y ___N
I give permission to the doctor and staff to discuss my medical condition with:
my family ___Y ___N other healthcare providers ___Y ___N

Signature ______________________________ Date ________________

Date ____________________ Name ____________________

Please answer the following questions:

FAMILY HISTORY:

If anyone in your family has had any of these diseases please list family member:

Melanoma ____________________ Psoriasis ____________________ Eczema ____________________

Other skin cancer ________________ Season Allergies ______________ Other ____________________

SOCIAL HISTORY:

What is your occupation? (if retired, list past occupation) ____

Do you use tobacco? ____ Yes ____ No Do you drink alcohol? ____ frequently ____occasionally ___ never

REVIEW OF SYSTEMS:

Please check any of the following problems that you have or have had:

SKIN
____keloids
____poor healing
____rash
____other __________

HEMATOLOGIC/ LYMPHATIC
____anemia
____bleeding problems
____enlarged lymph nodes

CONSTITUT. SYMPTOMS
____weight loss
____fever
____weak, tired

EARS/EYES/NOSE THROAT
____glaucoma
____hearing aid
____cosmetic surgery

CARDIOVASCULAR
____angina,heart attacks
____heart valve problems
____pacemaker
____high blood pressure

RESPIRATORY
____asthma
____emphysema
____other lung problems
____allergies

PSYCHIATRIC
____depression
____anxiety attacks
____other _______

MUSCULOSKELETAL
____arthritis
____artificial joints
____aching joints

NEUROLOGICAL
____stroke
____seizures
____headaches
____dizziness

GASTROINTESTINAL
____stomach ulcers
____colitis
____other GI problems

INFECTIONS
____hepatitis
____HIV/AIDS
____TB
____urinary tract

ENDOCRINE
____diabetes
____thyroid problems
____other _________

CANCER: _____skin ____lung ____breast ____colon ____other ________________________

MEDICATIONS: ____

____

Consent to Release Personal Health Information

and Acknowledgement of Receipt of Notice of Privacy Practices of Family Dermatology

Specialists, LLC

Family Dermatology Specialists, LLC reserves the right to modify the privacy practices outlined in the notice.

I, individually or on behalf of the patient, authorize **Family Dermatology Specialists, LLC** to use and disclose my health information as required for treatment, payment, and healthcare operations as described in **Family Dermatology Specialists, LLC's** Notice of Privacy Practices.

I hereby acknowledge that I was given a copy of **Family Dermatology Specialists, LLC's** Notice of Privacy Practices on the date written below.

____

Name of Patient (PRINT)

____

Signature

____

Date

If signed by personal representative, relationship to patient.

____

Office Use Only

If **Family Dermatology Specialists, LLC** in unable to obtain an acknowledgement of receipt of the Notice of Privacy Practices, explain why:

____

____ ____________________

Family Dermatology Specialists, LLC's employee signature Date

family dermatology
SPECIALISTS, LLC

3421 North Causeway Blvd., Suite 202 Metairie, La. 70002

Phone: (504)832-6612 Fax: (504)832-6613

Credit Card Policy

Family Dermatology Specialists, LLC has implemented a credit card policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the patient's responsibility. At that time, any remaining balance owed by you that is less than $100.00 will be charged to your credit card. A copy of the transaction will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us your payment. As we move forward in our practice, this will alleviate elevating cost that would be passed on to our patients and help to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, coinsurance, and deductibles are due at the time of service.

If you have any questions regarding this payment method, please do not hesitate to ask.

I AUTHORIZE FAMILY DERMATOLOGY SPECIALISTS, LLC TO CHARGE OUTSTANDING BALANCES ON MY ACCOUNT TO THE FOLLOWING CREDIT CARD OR DEBIT CARD:

VISA / MASTERCARD / DISCOVER / AMERICAN EXPRESS (CIRCLE ONE)

ACCOUNT NUMBER: __________-__________-__________-__________ EXP. DATE:__________CVV CODE (2 DIGIT CODE ON BACK OF CARD):__________ ZIP CODE:__________

CVV CODE (4 DIGIT CODE ON FRONT OF CARD FOR AMERICAN EXP:____________

NAME ON CARD (PLEASE PRINT)____

SIGNATURE:__________________________ DATE:_____________________

OPT IN WITHOUT PRIOR CALL_____ OPT IN WITH PRIOR CALL_____ OPT OUT_____