P: 501-623-6100
F: 501-623-6187

New Patient Registration Form

THE DERMATOLOGY CLINIC

Patient Name :

Date of Birth : | **SSN :**

Address :

City : | **State :** | **Zip :**

County : | **Place of Birth** (City / State) **:**

Home Phone # :

Cell Phone # :

Work Phone # :

Would You Like To Receive Text Message Reminders For Future Appointments?

◯ **YES** ◯ **NO**

(Please Check One)

Email :

Sex :

◯ Male
◯ Female

Race :

◯ American Indian
◯ Asian
◯ Black/African American
◯ White
◯ Other
◯ Declined

Ethnicity :

◯ Hispanic - Latino
◯ Not Hispanic - Latino
◯ Other
◯ Declined

Marital Status :

◯ Married
◯ Divorced
◯ Single
◯ Widowed

Language :

Primary Care Physician :

Referring Physician :

Pharmacy Name :

Pharmacy Phone # or Zip Code :

******IF PATIENT IS A MINOR******

Legal Guardian : _____

Legal Guardian Date of Birth : _____

By signing below, I authorize the release of medical information necessary to process this claim and also authorize payment of benefits to the physician.

◯ Medicare ◯ Medicaid ◯ Private Insurance
(Please Check One)

_____
Patient / Guardian Signature

_____
Date

THE DERMATOLOGY CLINIC

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office.

Payment is required in full for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payment and deductibles will be collected.

Any unpaid balance, after insurance payment, is due from the patient. Since our relationship is with the patient, the bill is the patient's responsibility. The patient will receive a monthly statement any time there is a balance on the patient's account that is considered patient responsibility. **If the entire balance cannot be paid in full, our business office can arrange a payment plan for the patient.**

Co-pays are due at the time of treatment. These amounts vary depending upon which managed health care plan the patient may have.

Payments Accepted: **Cash, Check, VISA, MasterCard, Discover, or American Express**

There is a $25.00 charge to the patient for returned checks due to insufficient funds or closed accounts.

We accept Medicare assignment and participate in a number of HMO's, PPO's and other managed care plans. We must have a copy of the patient's insurance card and all insured party information including date of birth and social security number to process the claim.

Financing options are available through CareCredit Please inquire at checkout.

MEDICAL RECORDS

Patient fee for copying of records is $.50 per page for the first 25 pages, and $.25 per page thereafter.
Please review your Explanation of Benefits from your insurance carrier.

If you have any questions or feel you are due a refund from The Dermatology Clinic, please contact our billing office at (501) 623-6100. We are always willing to be of assistance to you.

Your signature below signifies your understanding and willingness to comply with this policy.

X_____ _____

Patient Signature Date

THE DERMATOLOGY CLINIC

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

Your signature consents to use and disclosure of your protected health information for treatment, payment & health care operations. You have the right to revoke this Consent, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Dermatology Clinic is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations;
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice;
- The Practice reserves the right to change the Notice of Privacy Policies;
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions;
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease;
- The Practice may condition treatment upon the execution of this Consent.

Would you like a copy of the HIPAA Notice of Privacy Form? ☐ Yes ☐ No

Do we have your permission to:

Leave a message on your cell phone answering machine? ☐ Yes ☐ No ☐ N/A
Leave a message at your place of employment? ☐ Yes ☐ No ☐ N/A
Discuss your medical condition with anyone other than yourself? ☐ Yes ☐ No ☐ N/A
If yes, with whom:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

X_____ _____
Patient / Representative Signature Date

_____ _____
Representative Relationship to Patient Date

THE DERMATOLOGY CLINIC
OF ARKANSAS

HISTORY AND INTAKE FORM

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH (Benign Prostatic Hyperplasia)
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension
High Blood pressure
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Implants
Breast Reduction
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colon: Colostomy
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
PTCA
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Removed
Liver Transplant
Liver Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Tubal Ligation
Pancreas Removed
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP (Prostate Removal)
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Squamous Cell Carcinoma
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids

THE DERMATOLOGY CLINIC
OF [illegible]

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

Other: _____

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

Do you have a family history of Melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____

Medications: (Please enter all current medications, dosage and how often it is taken)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: (Please enter all **MEDICATION** allergies)

_____
_____
_____
_____
_____
_____

THE DERMATOLOGY CLINIC
OF ARKANSAS

Social History (please circle one)

Cigarette Smoking:
Currently Smokes
Never smoked
Former Smoker

Language:
English
Spanish
Other: _____

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Driving Status:
Drives in the Daytime
Drives at Night

Race:
White
Black/African American
American Indian
Native Alaskan
Other: _____

How Often do you exercise?
Once a day
A few times a week
A few times a month
Never

Caffeine use
Once a day
A few times a week
A few times a month
Never

Alcohol Use:
None
less than 1 drink per **DAY**
1-2 drinks per **DAY**
3 or more drinks per **DAY**

Occupation and Workplace: _____

THE DERMATOLOGY CLINIC
OF ARKANSAS

REVIEW OF SYSTEMS

New / Referred Patient

Problems with Healing	Yes	No
Problems with Scarring	Yes	No
Rash	Yes	No
Photosensitivity	Yes	No
Nodules / Other Types of Lesions	Yes	No
Fever Blisters / Oral Herpes Infections	Yes	No
Genital Lesions	Yes	No
History of Shingles	Yes	No
Problems with Bleeding	Yes	No
Swollen / Tender Lymph Nodes	Yes	No
Immunosuppression	Yes	No
Hay Fever	Yes	No
Chest Pain	Yes	No
Palpitations	Yes	No
Fever or Chills	Yes	No
Frequent Infections	Yes	No
Fatigue / Malaise	Yes	No
Night Sweats	Yes	No
Unintentional Weight Loss	Yes	No
Unintentional Weight Gain	Yes	No
Thyroid Problems	Yes	No
Blurry Vision	Yes	No
Abdominal Pain	Yes	No
Nausea / Vomiting	Yes	No
Constipation / Diarrhea	Yes	No
Bloody Stool	Yes	No
Bloody Urine	Yes	No
Menopause	Yes	No
Joint Aches	Yes	No
Muscle Weakness	Yes	No
Neck Stiffness	Yes	No
Arthritis	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Cough	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Insomnia	Yes	No
Sore Throat	Yes	No
Thrush	Yes	No

THE DERMATOLOGY CLINIC
OF ARKANSAS

REVIEW OF SYSTEMS
New / Referred Patient

Blood Thinners	Yes	No
Aspirin	Yes	No
Pacemaker	Yes	No
Defibrillator	Yes	No
Artificial Heart Valve Within Last Two Years	Yes	No
Rapid Heartbeat with Epinephrine	Yes	No
Allergy to Lidocaine	Yes	No
Allergy to Adhesive	Yes	No
Allergy to Latex	Yes	No
Allergy to Topical Antibiotic Ointment	Yes	No
Premedication's Prior to Procedures	Yes	No
Pregnancy or Planning a Pregnancy	Yes	No
MRSA	Yes	No
HIV	Yes	No
Hepatitis	Yes	No

X_____ _____

Patient Signature D.O.B.