Patient Demographic

Date ______/______/______

Patient Name____ Sex ☐ M ☐ F

First Middle Last

Patient Address ____

Street Apt#

____

City State Zip

Phone # ______–______–______ ______–______–______ ______–______–______

Home Work Cell

Date of Birth ______/______/______

Insurance Provider ____

Member ID ______________________________ Group #____________________________

Insured Party/Person Responsible for Payment

Name ____ Sex ☐ M ☐ F

Address ____

City ____

State ________________ Zip ______________________

Date of Birth ______/______/______

Relationship to Patient ____________________________________

Arlington Dermatology Clinic, PC
801 Road to Six Flags W. Ste #139
Arlington, TX 76012
Tel: 817-265-1356 Fax: 817-261-4309

Patient Information

Patient Name:____ MRN#____________

Phone Numbers:

Home:______________________ Work:_____________________ Cell:________________________

Which is your preferred contact for phone calls from our office? Home Work Cell

How would you like to be reminded of appointments? Home Email Cell (Text Message) Cell (Not by Text Message) No Reminders

Is it ok to leave detailed messages? Yes No

Email:

Email address:____

Would you like to receive e-mail notifications about your appointments? Yes No

Would you like to be part of our Patient Portal? Yes No

The Patient Portal allows you to view your appointments, medial records, and pathology/lab results. You can also use it to update your contact information and medications, and to directly message our office wit any questions or concerns you may have.

Personal Information:

Language (for appointment reminders only): English Spanish Other _______________

Race:

Asian American Indian or Alaska Native Black or African American White/Caucasian

Native Hawaiian or Pacific Islander Other Race Decline to Specify

Ethnicity:

Hispanic or Latino Not Hispanic or Latino Unknown Decline to Specify

Emergency Contact:

Name ____ Phone ______________________________

Spouse:

Name ____ Phone ______________________________

Caretaker (if applicable):

Name ____ Phone ______________________________

Patient Employer:

Name ____ Occupation ______________________________

Seasonal Address (if applicable):

____ Date Range: ______________________

____

We greatly appreciate your time!

Patient Signature: ____ Date: _________________

Office Use Only

Information Entered By: ________________________________ Date_______________

Medical History

Patient: ______________________________ Date: ____________

Are you allergic to any medications? ☐ YES ☐ NO If YES, please list:

____

List all medications you are currently taking:

____

____

Do you currently have, or have a history of any of the following conditions? If YES, please explain on lines below.

	YES	NO		YES	NO		YES	NO
Anxiety	☐	☐	Diabetes	☐	☐	Irregular Heartbeat	☐	☐
Arthritis	☐	☐	End Stage Renal	☐	☐	Pacemaker	☐	☐
Artificial Joints	☐	☐	GERD	☐	☐	Leukemia	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Lung Cancer	☐	☐
Blood Clots	☐	☐	Hearing Loss	☐	☐	Lymphoma	☐	☐
BPH	☐	☐	Hepatitis	☐	☐	Prostate Cancer	☐	☐
Breast Cancer	☐	☐	High Blood Pressure	☐	☐	Radiation Treatment	☐	☐
Colon Cancer	☐	☐	High Cholesterol	☐	☐	Seizures	☐	☐
COPD	☐	☐	HIV	☐	☐	Stroke	☐	☐
Coronary Artery Disease	☐	☐	Hyperthyroidism	☐	☐	Ulcerative Colitis	☐	☐
Depression	☐	☐	Hypothyroidism	☐	☐	Other (specify below)	☐	☐

____

____

List any surgical procedures you have had in the last 6 months:

____

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO If YES, any bad reaction? ☐ YES ☐ NO

When exposed to sun, do you: ☐ Tan Only ☐ Tan and Burn ☐ Burn

Do you have a history of any of the following skin conditions?

	YES	NO		YES	NO		YES	NO
Acne	☐	☐	Eczema	☐	☐	Poison Ivy	☐	☐
Basal Cell Skin	☐	☐	Flaking/Itchy Scalp	☐	☐	Psoriasis	☐	☐
Blistering Sunburns	☐	☐	Keloid Scars	☐	☐	Squamous Cell Skin Cancer	☐	☐
Dry Skin	☐	☐	Melanoma	☐	☐	Other Skin Condition (specify below)	☐	☐

____

Do you have a family history of skin cancer? ☐ YES ☐ NO If yes, who? ____________________

Do you drink alcohol? ☐ YES ☐ NO If yes, __________ drinks per day

Do you use IV drugs? ☐ YES ☐ NO If yes, what? ____________________ How often? ______________

Do you smoke? ☐ Never ☐ Past ☐ Currently ☐ Currently Other Tobacco User

Are you currently pregnant or planning a pregnancy? ☐ YES ☐ NO

Do you bleed easily? ☐ YES ☐ NO

What is your occupation? ______________________________

What are your hobbies? ______________________________

Arlington Dermatology Clinic, PC
Dr. Mary Adams, MD
801 Road to Six Flags W. Ste #139
Arlington, TX 76012
Tel: 817-265-1356 Fax: 817-261-4309

Consent Form

I consent to the use or disclosure of my protected health information by **Arlington Dermatology Clinic** (**ADC**) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations of **ADC**. I understand that the diagnosis or treatment of me by **Dr. Mary Adams** may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry to treatment, payment, or healthcare operations of the practice. **ADC** is not required to agree to the restrictions that I may request. However, if **ADC** agrees to a restriction that I request, the restriction is binding on **ADC** and **Dr. Mary Adams**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Mary Adams** or **ADC** has taken action in reliance on this consent.

My (protected health information) means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review **ADC** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of **ADC**. The Notice of Privacy Practices for **ADC** is also provided **in the HIPAA notebook located on the bookshelf in Dr. Mary Adams' office**. This Notice of Privacy Practices also describes my rights and the **ADC** duties with respect to the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

Please list the name and relationship of the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

____

May our office contact you at home with calls concerning appointment results from pathology, lab work, or any other healthcare info?

YES ____ NO____

Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail?

YES ____ NO____

On your work answering machine or voicemail? YES ____ NO____

I understand I am responsible for all charges whether covered by my insurance provider or not.

Signature of Patient or Patient Representative

____

_______________________________________ _______________________________________
Name of Patient or Patient Representative Description of Representative's Authority

Arlington Dermatology Clinic, PC
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, paper, or orally, are kept properly confidential. This Act gives you, the patient, signifiant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your information and how we may use and dispose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations:

Treatment means providing, coordinating, or managing healthcare and related services by one or more providers.

Payment means such activities as receiving reimbursement for services, confirming coverage, billing or collection activities, and utilization review. And example would be sending a bill for your visit to your insurance company for payment.

Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent to that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to receive of accounting disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free Call Center: 1-800-368-1019
TTD Number: 1-800-537-7697
www.hhs.gov/hipaa