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Thank you for scheduling an appointment with Magnolia Dermatology. It is our pleasure to welcome you to our practice and to your first appointment. The following information will help familiarize you with our practice.

Insurance and Payment

We accept most insurances and will file your insurance as a courtesy to you. It is our policy to collect any co-payment, deductible, and/or co-insurance at the time of service. It is important for you to understand your insurance benefits, network status, and covered services. If you are receiving cosmetic services or aesthetic procedures, full payment is required at the time of service as these services are not covered by insurance. We accept cash, credit cards, money orders, and CareCredit®.

Cancellation Policy

If any scheduling conflicts arise, we are happy to reschedule your appointment to a time that is more convenient for you. Please be advised that we require at least a 24-hour notice to cancel or reschedule an appointment. Cancellations or rescheduled appointments made less than 24 hours from your appointment time will be charged a $25.00 fee which must be paid prior to being seen.

Clinic Hours and Communications

Our clinic is open Monday to Thursday from 8:00am until 5:00pm, and on Friday from 8:00am until 1:00pm. You may reach us by phone, email, secure text, or by a direct message from your patient portal. Please allow 48 hours for us to respond to any message or refill request.

Forms and Documents

Please complete the new patient forms. Also, please bring the following documents to the clinic for your appointment:

- ☐ Driver's license or other government-issued identification card
- ☐ Insurance card(s): If you would like us to file your insurance
- ☐ List of current medications and allergies

New Patient Information Form

Name: _____ **Birthdate:** ___/___/___

Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: (___) ___-_____ **Cell Phone**: (___) ___-_____ **SSN**: ___-___-_____

Email: _____ ☐ Check if you would NOT like to receive our monthly email newsletter

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Ethnicity: ☐ Asian ☐ Black/African American ☐ Hispanic ☐ White/Caucasian ☐ Other:_____

Preferred Language: ☐ English ☐ Spanish **Preferred Communication**: ☐ Call ☐ Text ☐ Email

In emergency notify: _____ **Relationship**: _____ **Phone**: (___) ___-_____

INSURANCE: Please provide a copy of your insurance card

Name of Member/Subscriber: _____ Birthdate: _____ Relationship: _____

AUTHORIZATION:

I authorize the following people to have unlimited access to my Protected Health Information (PHI*; ie:* any and all of my medical information).

Name: _____ Relationship: _____

_____ _____

TREATMENT AND PAYMENT AGREEMENT:

- I authorize examination and treatment for this and all following physician visits.
- I authorize to release any medical information necessary to process insurance billings.
- I authorize payment and assignment of insurance benefits to the doctor's office.
- I am personally responsible for supplying accurate and current insurance information.
- I understand I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information.
- I authorize a photocopy of this statement to serve as an original
- I have read and understand the policy regarding failure to appear for appointments and appointment cancellations
- I authorize Magnolia Dermatology to verify my medications/prescriptions through my pharmacy and Surescripts
- I authorize Magnolia Dermatology to contact me via text or email communication.
- I have reviewed the notice of Privacy Practices (please see attachment) and understand the address location and contact information for the complete HIPAA-1996, and the Privacy Officer for this office is available upon my request, and also that compliance complaints can be made to the Department of Health and Human Services.

Signature of Patient/Guardian: _____ **Date**: ___/___/___

Parent/Guardian Printed Name (if minor): _____

Name: _____ **Birthdate:** ___/___/_____

ALLERGIES

☐ No Known Drug Allergies
☐ Sulfa Medications (Reaction: _____)
☐ Penicillin Antibiotics (Reaction: _____)
☐ Codeine (Reaction: _____)
☐ Other_____ (Reaction: _____)
☐ Other_____(Reaction: _____)

MEDICAL HISTORY

Do YOU currently have any of the following symptoms:

Constitutional: ☐ Weight loss ☐ Fevers ☐ Night sweats ☐ Fatigue
Skin: ☐ Rash ☐ Itching ☐ Problems healing

Do YOU have a history of any of the following diseases/conditions:

☐ Basal cell skin cancer
☐ Squamous cell skin cancer
☐ Melanoma: (when:_____)
☐ Eczema
☐ Psoriasis
☐ Asthma/COPD
☐ Heart disease/High blood pressure
☐ Diabetes
☐ Immunosuppression/HIV
☐ Liver Disease/Hepatitis
☐ Tuberculosis
☐ High Cholesterol
☐ Poor wound healing or keloid scars
☐ Arthritis
☐ Glaucoma
☐ Crohn's disease/Ulcerative Colitis
☐ Blood Clots
☐ Cancer (type:_____)
☐ Other: _____

Females: Are YOU currently:

Pregnant: ☐ Yes ☐ No ☐ Not applicable
Breastfeeding: ☐ Yes ☐ No ☐ Not applicable

SURGICAL HISTORY

☐ Pacemaker/Defibrillator
☐ Gallbladder
☐ Cancer-related surgery
☐ Hysterectomy
☐ Hernia
☐ Stent placement
☐ Appendix
☐ Joint Surgery
☐ Other Implanted devices
☐ Other: _____

FAMILY HISTORY: Does anyone in your family have:

☐ Melanoma
☐ Psoriasis
☐ Acne
☐ Cancer (Type: _____)
☐ Neurological disease (Multiple Sclerosis)
☐ Heart Disease
☐ Inflammatory Bowel Disease
☐ Other: _____

CURRENT MEDICATIONS and DOSAGE: ☐ Check if copy of medication list attached

_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

Smoker: ☐ Never ☐ Quit ☐ Current **Alcohol Use**: ☐ Never ☐ Social ☐ Daily ☐ Past

Occupation: _____ **Employer**: _____

HEALTHCARE INFORMATION

Pharmacy: _____ **Location**: _____ **Phone**: ( ) -

Primary Physician: _____ **Referring Physician**: _____