MAGNOLIA
DERMATOLOGY

Patient Name: ______________________________ Birthdate: ____________________

_________ Initials

Insurance and Payment

Your insurance is a contract between you, your employer, and your insurance company. **It is your responsibility to understand your insurance benefits, network status, and covered services.** Magnolia Dermatology accepts 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. Dermatologists are skin specialist, your copay for specialist may differ. **Some insurance plans exclude certain diagnoses, such as hair loss, sweating, corns, or calluses. Please verify coverage prior to your appointment.** If you receive cosmetic or aesthetic services, full payment is required at the time of service as these services are not covered by insurance. **You understand you are financially responsible for any amount not covered by your insurance.** If you have any difficulty paying your account, a payment plan may be available.

_________ Initials

General Consent to Treatment

I agree and consent to a physical examination by the providers at Magnolia Dermatology. I understand that additional diagnostic procedures and treatment may be recommended**. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedure or medical treatment**.

_________ Initials

Cancellation Policy and Late 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 prior to your appointment time will be charged a $25.00 fee**. We ask that you arrive early for your scheduled appointment to complete forms or update any information or insurance. **Patients arriving more than 15 minutes after their scheduled appointment may have to be rescheduled**.

_________ Initials

Pathology

If you have a biopsy or procedure performed, all specimens will be sent to an independent lab, *Skin Diagnostics*, for examination by a pathologist. *Skin Diagnostics* will process and file your insurance. You will receive a separate bill from *Skin Diagnostics* for any amount not covered by your insurance.

_________ Initials

Laboratory

If you have blood drawn it will be sent to a separate, independent laboratory, *Labcorp*, for processing. *Labcorp* will process and file your insurance. You will receive a separate bill from them for any amount not covered by your insurance.

_________ Initials

Privacy Practices

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. I understand that compliance complaints can be made to the Department of Health and Human Services.

_________ Initials

Authorizations

- I authorize the release any medical and billing information to physicians or institutions providing care and to my insurance company.
- I authorize Magnolia Dermatology to contact me via text or email communication.
- I authorize a photocopy of this statement to serve as an original.

______________________________ ____________

Signature of Patient or Parent/Guardian *Date*

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 ☐ Other **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

Reason for Visit: ☐ Spot or Skin Check ☐ Rash ☐ Acne ☐ Hair loss ☐ Nail Problem ☐ Other: ____________

Parent Information: *If patient is a minor, please complete*

Parent's Name ______________________ Cell Phone: ____________

Parent's Name ______________________ Cell Phone: ____________

Any custody issues we should be aware of, please describe:

____

INSURANCE: *Please provide a copy of your insurance card*

Name of Subscriber/Cardholder: ____________ Birthdate: ____________ Relationship: ____________

Emergency Contact: *In case of an emergency please contact*

Name: ____________ Phone Number: ____________ 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: ______________________

Name: ______________________ Relationship: ______________________

______________________ ____________

Signature of Patient or Parent/Guardian *Date*

Name: ______________________________ **Birthdate:** ___/___/___ **Reason for visit:** ______________________________

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/where:_____________)
- ☐ 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**: ____________________