



Patient Information

Referred by:					
Name:		<small>(Last)</small>	<small>(First)</small>	<small>(Middle)</small>	
Mailing Address:		<small>(Street)</small>	<small>(City)</small>	<small>(State)</small>	<small>(Zip)</small>
Phone Numbers:		<small>(Home)</small>	<small>(Cell)</small>	<small>(Work)</small>	
Date of Birth:		<small>(MM)</small>	/	<small>(DD)</small>	/
		<small>(YYYY)</small>	Gender: Male Female		SSN:
Marital Status:		Single	Married	Divorced	Widowed
Are you employed?		Yes	No	Full-Time	Part-Time
		Retired	Unemployed		
Employer:		<small>(Company Name)</small>		<small>(Address)</small>	
Emergency Contact:		<small>(Name)</small>	<small>(Relationship)</small>	<small>(Phone)</small>	
Primary Insurance:		<small>(Name)</small>			<small>(Phone)</small>
Policy Number:		Group Number:			
Policy Holder:		<small>(Name)</small>	<small>(Date of Birth)</small>	<small>(Relationship to you)</small>	
Policy Holder's Employer:		<small>(Name)</small>			<small>(Address)</small>
Secondary Insurance:		<small>(Name)</small>			<small>(Phone)</small>
		<small>(if applicable)</small>			
Policy Number:		Group Number:			
Policy Holder:		<small>(Name)</small>	<small>(Date of Birth)</small>	<small>(Relationship to you)</small>	
Policy Holder's Employer:		<small>(Name)</small>			<small>(Address)</small>
If you are a minor, who is the responsible party?		Do you have Advanced Directives?		Yes	No
		Do you have a Power of Attorney?		Yes	No

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment to Integrated Dermatology for any medical benefits payable to me for the services provided at Integrated Dermatology. I understand that if my insurance plan requires a referral authorization, it is my responsibility to obtain a referral prior to the appointment and I will be held financially liable for any failure to furnish the proper authorization to be seen.

Patient/Guardian Signature

Date



Patient Information

Date:	Referring Physician:		
Patient Name:	(Last)	(First)	(Middle)
Reason for visit:	Rash	Growth	Other: (Please explain here.)
Location of Problem and aggravating factors:			Age:
			Duration:

List any Medication Allergies:

Please check any symptoms, signs, or conditions you are currently experiencing:

Fever	Non-Healing Sores	Soreness of Skin	Skin Rash, Itching/Burning	Chest Pain/Shortness of Breath
Weight Loss	Mole Changes	New Growth	Nausea/Vomiting/Diarrhea	Soreness of External Genital
Joint Pain	Cough/Runny Nose	Eye Tearing/Drainage	Mental Status Changes	Bleeding/Bruising Problems
Dizziness	Numbness/Tingling	Others:	None	

Past Medical History / Family History / Social History

Disease	Yourself	Family	Disease	Yourself	Family	Disease	Yourself	Family
Acne			Fever Blister			Liver Disease/Hepatitis		
Asthma/Hay Fever			Heart/Renal Transplant			Psoriasis		
Bleeding Disorder			Heart Valve/Murmur			Recurrent yeast Infection		
Depression			High Cholesterol			Skin Cancer		
Diabetes			Kidney Disease			Melanoma		
Eczema			Joint Replacement			Thyroid Disease		

Question	Yes	No	Question	Yes	No
Do you take blood thinner/aspirin or Coumadin?			Do you wear sunscreen?		
Do you have a pace maker or artificial valve?			Have you ever used a tanning bed?		
Do you drink alcohol? How often?			Have you ever had a blistering sunburn?		
Are you a student?			Date of last menstrual period?		
What is your occupation?			Are you planning a pregnancy?		
What outdoor activities do you participate in?					

Current medication including PRESCRIPTION AND OVER THE COUNTER, VITAMINS, HERBS, OR BIRTH CONTROL PILLS:

Daytime Phone:	Evening/Cell Phone:	Preferred Pharmacy:
Patient Signature:		Date:



INTEGRATED DERMATOLOGY

Ronald M. Harris, M.D., M.B.A.
2270 S. Ridgeview Drive, Suite 302
Yuma, Arizona 85364
info@idermyuma.com
(928) 783-0169

Information, Patient Financial Policy and Signature on File

Patient Name: (Last) (First) (Middle)	Date:
Other Family Members that are patients:	
Primary Care Physician: (Name) (Phone Number)	

EMERGENCY CONTACT INFORMATION

In case of an emergency, who should be notified?	(Phone)
Do you give our office permission to discuss your medical information with family members? Yes No	If yes please provide their names and numbers below.
Name: (Relationship)	(Phone)
Name: (Relationship)	(Phone)
May we leave personal medical information on your answering machine at home? Yes No	
May we email personal medical information to you? Yes No	Email address:

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicate that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (*Notice of Privacy Practices*). I have been given the option of signing a separate patient consent form.

Patient or Responsible Party Signature: Date:

Cancellation Policy: We require 24 hour notice for cancellation of your appointment. A no-show without calling the office will result in a charge of \$50.00 at the responsibility of the patient. This will not be billed to your insurance company.

PAYMENT POLICY

HMO,PPO, or other managed care patients:

You will be responsible for paying your annual deductible, co-payment, and charges for any non-covered cosmetic services.

Patient or Responsible Party Signature: Date:



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HIPPA Patient Consent Form

Integrated Dermatology's 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.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. This practice provides this form to comply 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 notices.
- The practice reserves the right to change the Notice of Privacy Practices.
- 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 receipt of treatment upon the execution of this consent.

This consent was signed by:

Name: (Please Print)

Authorized Signature

Date: