Dermatology of Santa Fe, PC

Patient Registration

Please PRINT clearly and complete ALL sections

Patient's Personal Information Marital Status: ☐ Single ☐ Married ☐ Partner Sex: ☐ F ☐ M

First Name _____ *Last Name* _____ Initial _____

Date of Birth _____ (mm/dd/yyyy) Social Security Number _____ (xxx-xx-xxxx)

Mailing Address _____

City _____ State _____ Zip Code _____

Primary #(_____) _____ Secondary #(_____) _____

Email _____

Employer _____ Phone # _____

Patient's Insurance Information

Primary insurance company's name _____

Secondary Insurance Company's Name _____

Primary Policy Holder of insurance

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

First Name _____ *Last Name* _____

Social Security Number _____ Primary # (____) _____

Emergency Contact

Name _____ Relationship _____

Phone # (_____) _____

Dermatology of Santa Fe, PC

Name _____

Referring Physician _____

Medications _____

Allergies _____

Medical History:

Y	N		Y	N	
☐	☐	High blood pressure	☐	☐	Asthma
☐	☐	Heart disease	☐	☐	Leg swelling
☐	☐	Stomach/ulcer	☐	☐	Headaches/migraines
☐	☐	Seizures	☐	☐	Hepatitis
☐	☐	Immune suppression	☐	☐	Diabetes
☐	☐	Blood clots	☐	☐	Excessive bruising
☐	☐	Nervousness or depression	☐	☐	Thyroid
☐	☐	Problems with local anesthesia	☐	☐	Sudden weight loss or gain
☐	☐	Liver or gallbladder	☐	☐	Herpes or cold sores
☐	☐	Kidney disease	☐	☐	Inflammatory disease
☐	☐	Bleeding			
☐	☐	Pregnant			

Do you use sunscreen? _____

Have you had surgery recently? If so, state the type of surgery

_____

Have you or anyone in your family had skin cancer? If so, state the type

_____

Have you or anyone in your family had other types of cancer? If so, state the type

_____

Reason for your visit today? _____

SEE REVERSE SIDE

Dermatology of Santa Fe, PC

Patient Consent For Use And Disclosure
Of Protected Health Information
HIPAA Form

With my consent, Dermatology of Santa Fe, PC may use and disclose **Protected Health Information (PHI)** about me to carry out **Treatment Payment and Healthcare operations (TPO)**. Please refer to Dermatology of Santa Fe, PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology of Santa Fe, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised notice of Privacy Practices may be obtained by forwarding a written request to Dermatology of Santa Fe, PC's Privacy Officer at 2019 Galisteo Street, Suite N9-B, Santa Fe, New Mexico 87505.

With my consent, Dermatology of Santa Fe, PC may call my home or other designated location and leave a message on a voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent Dermatology of Santa Fe, PC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Dermatology of Santa Fe, PC restrict how its uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dermatology of Santa Fe, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology of Santa Fe, PC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date mm/dd/yyyy

_____
Print Name of Legal Guardian