Dermatology of Santa Fe, PC

2019 Galisteo Street, Building N, Suite 9B, 87505
505-986-9688

Name_____

Referring Physician _____

Medications_____

Allergies_____

Medical History:

Y/N High Blood Pressure	Y/N Asthma
Y/N Heart Disease	Y/N Leg Swelling
Y/N Stomach Ulcer	Y/N Headaches/migraines
Y/N Seizures	Y/N Hepatitis
Y/N Immune suppression	Y/N Diabetes
Y/N Blood Clots	Y/N Excessive bruising
Y/N Nervousness or depression	Y/N Thyroid disease
Y/N Problems with local anesthesia	Y/N Sudden weight loss or gain
Y/N Liver or gallbladder disease	Y/N Herpes or cold sores
Y/N Bleeding	Y/N Inflammatory disease
Y/N 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?

_____

Preferred Pharmacy _____

*(Please include city and/or cross streets)

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 _____ *Last 4 of Social Security #* _____

Mailing Address _____

City _____ *State* _____ *Zip Code* _____

Home #(_____) _____ *Cell Phone #(_____)* _____

Email _____

Employer _____

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* _____

Phone # (____) _____

Emergency Contact

Name _____ *Relationship* _____

Phone # (_____) _____

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 Dermatology of Santa Fe, PC may e-mail to my home or other designated location any time 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

_____
Print Name of Legal Guardian

Dermatology of Santa Fe, PC
COVID-19 Liability Release Form

At Dermatology of Santa Fe, we are trying to take every precaution to protect our patients and staff during this COVID-19 outbreak. We have added many different measures to screen patients that may be potentially infections or have had contact with people who are infectious. We kindly ask that this form be reviewed and signed before you are seen for your appointment.

Symptoms of COVID-19, include, but are not limited to the following:

-Fever
-Diarrhea
-Muscle aches/pains
-Loss of taste and/or smell
-Cough
-Difficulty breathing
-Nausea and/or vomiting
-Runny nose
-Headaches
-Fatigue
-Changes in color of lower legs and/or toes
-Chills

I _____ agree to the following, before being seen by either Beth Jester, MD, FAAD or Jessica Wood, PA-C, MSPAS at Dermatology of Santa Fe:

- I understand the above symptoms and affirm that I, as well as household members, do not currently have, nor have experienced symptoms listed above within the last 30 days.
- I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the last 45 days.
- I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
- I affirm that I, as well as household members, have not travelled outside of the country or to any city outside of our own, deemed unsafe or a "hot spot" for COVID-19 infections within the last 30 days.
- I understand that this business cannot be held liable for any exposure to the virus if any misinformation has been provided by each patient.

By signing below, I agree to each above statement and release Dermatology of Santa Fe from any and all liability for the unintentional exposure or harm due to COVID-19.

All employees of Dermatology of Santa Fe agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols and screening protocols to more thoroughly help reduce the spread of COVID-19.

Patient Signature _____ Date_____

Staff Signature _____ Date _____