Patient Registration / Medical History

Highlander Dermatology LLC

Name:_____
First *Middle* *Last*

Age:_____ **Date of birth:**_____/_____/_____

Address:_____
Street *City* *State* *Zip*

***Social Security #**_____-____-_____ Employer:_____Occupation:_____
*required for Medicare/government insurance

Primary Phone: (_____) _____-_____ Secondary Phone: (_____) _____-_____
__Home __Work __Cell *__Home __Work __Cell*

Reminders are sent by Text, Email and/or Phone. **Email**:_____

Subscriber Name (Responsible Party) *if different from the patient*

Name:_____ **Date of Birth:**_____-_____-_____
First *Last*

Address:_____
***if different from the above address** **Phone**

HIPAA PERMISSION

Our 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. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

[Y] **[N]** I give permission to discuss my medical information with my emergency contact
If yes, please provide the name/relationship/phone of your emergency contact

Name:_____/_____Phone:_____
Relationship

[Y] **[N]** May we leave medical information on your answering machine/voicemail?

_____
Signature of Patient or Legal Representative/Guardian ***Date***

_____
Printed name of Legal Representative/Guardian / Relationship to the patient

Medical History

Primary Physician :_____
city

Referring Physician:_____
city

Pharmacy Local:_____/_____/_____
Name *Location* *Phone*

Pharmacy Mail Order**:**_____/_____/_____
Name *Location* *Phone*

Race/Ethnicity:
[ ] African American [ ] Asian [ ] Caucasian [ ] Hispanic [ ] Native American [ ] Other [ ] Declines

Smoking status: [ ] Current smoker [ ] Former Smoker [ ] Never Smoker

Alcohol intake: [ ] consume alcohol. If yes, number of times per year you have over 4 drinks in a day _____

ALLERGIES

Medication allergies:_____

Other allergies:_____

Please list your current Medications (medication/dose/times taken per daily)

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

7)_____ 8)_____ 9)_____

Do you have now, or have you ever had any of the following:

[ ]	Asthma	[ ]	Thyroid disease	[ ]	High blood pressure
[ ]	Seasonal allergies	[ ]	Pacemaker	[ ]	High cholesterol
[ ]	Diabetes	[ ]	Tuberculosis	[ ]	Hepatitis B/C
[ ]	HIV	[ ]	Heart attack	[ ]	Joint replacement
[ ]	Depression/anxiety	[ ]	Crohn's/ulcerative colitis	[ ]	History of Pneumonia Vaccine

Other Medical and Surgical History:_____

_____

Skin Cancer History: **[ ]** Basal Cell Carcinoma **[ ]** Squamous Cell Carcinoma **[ ]** Melanoma

Family History of Melanoma [ ] _____ **or Pancreatic cancer [ ] or Autoimmune disease [ ]**
which family member

Cancer History: _____
please specify type, year, and treatment (chemotherapy or radiation therapy)