DERMATOLOGY MEDICAL HISTORY

Patient: _____ Date: ____/____/____

Reason for today's visit:_____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal	☐	☐
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea	☐	☐
when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months:

Skin: Have you ever had skin cancer?

Has anyone in your family had skin cancer? ☐ YES ☐ NO

Do you have a history of any specific skin diseases? ☐ YES ☐ NO If yes, _____

Do you have problems with healing ☐ YES ☐ NO

Do you develop keloids (scars) after surgery ☐ YES ☐ NO

Do you bleed easily? ☐ YES ☐ NO

Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin ☐ Other _____

Social History:

Do you drink alcohol? ☐ YES ☐ NO If YES _____ drinks per day

Do you use IV drugs? ☐ YES ☐ NO If YES, what? _____ How often? _____

Do you smoke? ☐ YES ☐ NO If YES, how much:

Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

Please answer the following questions:

(Women) Are you pregnant? ☐ YES ☐ NO Due Date: ____/____/____

What is your occupation? _____ Hobbies? _____

Completed by: ☐ Patient _____ ____/____/____

☐ Medical Assistant _____ Signed by Patient Date Date

Initials

_____ ____/____/____

Reviewed by Date

New Leaf Dermatology
Dr. Mark Meyers

Patient Registration & Medical History Date: ____/____/____

Name. _____ SSN# _____

Date of Birth _____ Gender: Male __ Female __ Marital Status: Single __Married __Divorced __Widowed __

Address 1 _____ City _____ State _____ Zip _____

Address 2 _____ City _____ State _____ Zip _____

Phone *(check preferred contact number)*

Home _____ Cell _____ Work _____

Email _____ May we send information to you at this email address? ___ Yes ___ No

Employer _____ Employer Address _____

Primary Care Physician _____ PCP Phone _____

Referring Physician PCP or Other Physician Name _____ Phone _____

If not referred, how did you hear about us? __ Website __ Physician __ Current Patient _____ Other _____

Pharmacy _____ Phone _____ Address _____

New Leaf Dermatology has my permission to give Biopsy/Lab Result or other messages:

___ To me ___ To other family members ___ To my spouse ___ On my answering machine ___ All of the options

GUARANTOR *(If Guarantor is the Patient Check Here and Skip to Next Section)*

Last Name: _____ First: _____ MI: ____ Date of Birth: ____/____/____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ SSN#: _____

Sex: _____ Marital Status: _____ Occupation: _____

Relationship to Patient: ____ Spouse ____ Parent ____ Legal Guardian

INSURANCE *Please present insurance card(s) with this form*

Primary Insurance: _____ Policy Holder: _____

Relationship to Patient: ___ Self ___ Spouse ___ Parent ___ Other Date of Birth: __ / __ / __ SSN: _____

Employer's Name: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____

Relationship to Patient: ___ Self ___ Spouse ___ Parent ___ Other Date of Birth: __ / __ / __ SSN: _____

If you are over **65 and Medicare is secondary, Please** list **reason:**

EMERGENCY CONTACT

Name: _____ **Phone: (___) _____ Relationship:** _____

In order to establish optimal relations with our patients and avoiding misunderstanding and confusion regarding our payment policies. Our staff are trained to consistently inform you of the financial payment policies of this office. A payment is expected from you at the time of service for your part of the charges. We accept payment in the form of cash. check or Credit card. If this account should be referred to a collection agency you will be responsible for any collection and or legal fees. Further, your signature authorized the release of Medical information to your primary care or referring physician or consultants as needed and as necessary to process insurance claims, insurance applications and Prescriptions. Your signature also authorized payment of medical benefits to the physician. Your signature below indicate that you understand accept the office policy and procedures.

Patient/Guardian Signature: _____ Date: _____

NEW LEAF DERMATOLOGY

YOU ARE ONE OF A KIND, SO IS OUR CARE

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payments.

We will submit your insurance claim to your carrier as a courtesy. Your insurance is a contract between you and/or your employer and the insurance company. We are not a party to that contract. You are responsible for whatever your insurance company does not pay in a timely fashion. If your insurance company does not pay the claim within 60 days of our filing the claim with them the balance billed will become your full responsibility and it will then be up to you to be reimbursed by your insurance carrier. Once your insurance pays their portion you will have 30 days to remit any additional balances due unless a payment arrangement has been extended to you.

Co-payments are required when you sign in at the front desk prior to being seen by the provider for all appointments to include follow-ups; however, no co-pay is required for suture removals.

A charge of $50.00 will be assessed for all missed appointments and cancellations under 24 hours. This will be due upon receipt of the statement or at the time your visit is rescheduled.

It is your responsibility to make sure we have the correct billing information i.e. insurance carrier, patient address, phone number, etc. Should we receive returned mail we will try the phone number listed in your file and if we are unable to contact you the account will be sent for further collections.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

_____
Signature

_____
Relationship to Patient

_____
Date Signed

715 S. Beeline Hwy | Ste. A | Payson, AZ 85541 | 928.468.6607 | 928.468.6658
www.newleafdermatology.com

NEW LEAF DERMATOLOGY

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Office Policies and Information

Business Hours	Our business hours are **Monday-Thursday 8-5 pm and 8-12 pm on Fridays**
Established Patients	Established patients may be required to fill out forms every year or as requested
Returned Checks	There is a **$25 charge** for all returned checks
Referral/Prior Authorization	It is your responsibility to obtain a referral from your Primary Care Giver to see a specialist (Dr. Meyers) if required by your insurance plan. If so, we must have it prior to your appointment or your appointment will be rescheduled. Any services denied by your insurance will be your responsibility.
Cosmetic Appointment	To ensure your appointment, a **50% deposit** is required for most cosmetic procedures. You might forfeit the amount if you do not show for your scheduled appointment. Once treatment begins there are no refunds on cosmetic services. In-house credit may be given in certain circumstances for alternative procedures.
Cosmetic Procedure	Your insurance company may consider some dermatological problems to be medically unnecessary to treat. Most cases skin tags, benign moles, seborrheic keratosis and all laser procedure are not covered by your insurance carrier. If you wish, we will be happy to treat on a fee for service basis. Check with Dr. Meyers or our Staff for the cost of these procedures before you have them treated. Our objective is to avoid a surprise for you at checkout.
Our Policy	**It is your responsibility to inform us of any changes in your insurance, telephone numbers and addresses.** We reserve the right to immediately cancel your care for conduct, non-cooperation or non-payment. **All co-payments, co-insurance, deductibles, fees and outstanding balances, fees, and outstanding balances must be settled before seeing Dr. Meyers or Staff.**

Patient Signature: _____ Date: _____

Acknowledgement Receipt: HIPPA Notice of Privacy Practices

By signing this form, you acknowledge that Mark Meyers, M.D. has given you the right to review and obtain a copy of the HIPAA Privacy Practices, which explains how your health information will be handled in various situations. If you would like to review the detailed form or obtain a copy, please see the receptionist.

Patient/Guardian Signature: _____ Date: _____

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