64231 HWY 434
Lacombe, LA 70445
Phone: (985) 202-3376 Fax: (985)_____

PATIENT INFORMATION

Patient Name:_____Title:: Mr./Mrs./Dr./Other:_____Suffix:_____

Gender:_____Date of Birth:_____Social Security #:_____

Mailing Address:_____City:_____State:_____ Zip:_____

Preferred Phone: (Cell / Home / Work):_____Other Phone: (Cell / Home /Work) _____

Marital Status:_____Occupation:_____ Language:_____Race:_____Ethnicity:_____

Primary Care Physician:_____ Referred by:_____

Email (Optional: **IF you would like to subscribe to monthly specials, marketing, etc*):_____

EMERGENCY CONTACT

Name:_____Relationship to Patient:_____ Phone:_____

INSURANCE INFORMATION

SEND STATEMENT TO: (If different from above)

Name:_____Title:: Mr./Mrs./Dr./Other:_____Suffix:_____

Mailing Address:_____City:_____State:_____ Zip:_____

Preferred Phone: (Cell / Home / Work):_____Other Phone: (Cell / Home /Work) _____

PRIMARY INSURANCE:

Insurance Company:_____ID#_____ Group#_____

Insured Name(Subscriber):_____ DOB:_____Social security#_____

Patient's Relationship to Insured (Subscriber): *SELF* *SPOUSE* *CHILD* *OTHER*

SECONDARY INSURANCE:

Insurance Company:_____ID#_____ Group#_____

Insured Name(subscriber):_____DOB:_____Social security#_____

Patient's Relationship to Insured (subscriber): *SELF* *SPOUSE* *CHILD* *OTHER*

I hereby authorize that the above listed insurance companies to pay directly to Malinski Dermatology due me, as provided in the above unexpired policy I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge amounts due from me, outstanding greater than 90 days will be eligible for collections. I authorize Malinski Dermatology to release information to the insurance company for my claims to be paid. Please attach a copy of my insurance card.

_____ _____

Signature Date

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New Patient Questionnaire

Name_____ Preferred Name:_____DOB:_____Date:_____
Weight:_____Height:_____Name and location of your pharmacy:_____
Reason for today's visit:_____

Your Past Medical History

Have you ever had any of the following medical problems?	YES	NO	Please give us any details
Anemia			
Asthma			
Autoimmune Disease(Lupus, Dermatomyositis, Rheumatoid Arthritis, other)			
Blood Clots			
Bleeding Disorder/prolonged bleeding after surgery			
Blood Transfusion			
Cancer (other than skin)			
Cardiac Problem			
Diabetes			
Endocrine disorder			
Gastrointestinal Disorder (GERD,stomach ulcers, Irritable Bowel Syndrome, Chron's Disease, Ulcerative Colitis, other)			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Lung Disease			
Need for antibiotic use prior to dental procedures			
Neurological Disorder (multiple sclerosis, other)			
Organ Transplant			
Pacemaker/Defibrillator			
Stroke			
Thyroid Disorder			
Psychological Disorder (anxiety, depression, other)			
Seasonal Allergies			
Tuberculosis or any other chronic infections			
Viral Infection (HIV/AIDS, Hepatitis A, B or C, CMV)			
Xray Therapy			
Other			

Your Past Surgical History (Last 10 Years)

Surgery/Hospitalization	Date	Anesthesia complications

Your Past Skin History

	Previous treatments	Treating Physician
Abnormal (Dysplastic)Mole(s)		
Acne		
Actinic Keratosis		
Allergic Contact Dermatitis		
Eczema		
Keloid Scarring/Poor Wound/Healing/Chronic Skin Ulcers		
Psoriasis		
Skin Rash in response to Medication or food		
Urticaria(Hives)		
Seborrheic Dermatitis		
Melanoma		
Other **Skin Cancers** or Suspicious Lesions		
Other		

Your Family History

	YES	NO	Family member/Details
Abnormal Bleeding			
Abnormal Clotting			
Autoimmune Disorders(Lupus, Dermatomyositis, Rheumatoid Arthritis, other)			
Cancer			
Diabetes			
Eczema/Atopic Dermatitis/Asthma			
Nonmelanoma Skin Cancer(Basal Cell Carcinoma, Squamous Cell Carcinoma, other)			
Melanoma Skin Cancer			
Endocrine Disease, other(including Thyroid disorders)			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Liver Disease			
Psoriasis			
Severe Acne			
Skin Disease, other			

Your Social History

	YES	NO		
Do you smoke?			For how long?	Year Start:
If not, have you ever smoked?			Year Started:	Year Ended:
Do you drink?			How much?	
Do you do drugs?				
Are you exposed to dust, solvents, or other chemicals?				
Are you pregnant or is there a chance you are?				
What is your occupation?				

Please list your medications (including over -the-counter medicines, hormones, birth control pills, and herbal remedies):

Please list any medication allergies you have and the reaction to each medication:

Office Policies

FINANCIAL POLICY

I hereby authorize that the listed insurance companies to pay directly to Malinski Dermatology due me, as provided in the unexpired policy I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge amounts due from me, outstanding greater than 90 days will be eligible for collections. I hereby acknowledge that if I am to use a *credit card* for payment, I will be assessed a 3% processing fee.

NO SHOW POLICY

In fairness to other patients, we require at least a 24 hour notice prior to cancelling an appointment. Should you miss an appointment without giving our office a 24 hour notice, **you may be subject to a no-show fee of $ 50.00**.

LATE ARRIVALS

As courtesy to our patients, we make every effort to see everyone on time. In the event that you arrive late for your scheduled appointment time, we will make every attempt to see you in a timely manner. However, please understand that patients with scheduled appointments will be seen first. If you cannot wait and would like to reschedule, our patient relations coordinator will be happy to assist you.

*If you are more than **15 minutes late**, it may be necessary to reschedule your appointment*

COSMETIC VS MEDICAL NECESSITY

Your medical insurance DOES cover the discussion of and treatment of medically necessary conditions. If you are not sure about a skin issue/lesion- please DO ask about it.

Requests are frequently made to remove lesions that are NOT medically necessary or to discuss “cosmetic” issues. In these cases, after we have concluded the regular office visit, the medical assistant will provide you with a fee schedule for any non-covered issues. If you desire to treat any non-covered issues, we will try our best to complete the service same day. There will be some cases in which a separate or follow up appointment made be scheduled to complete the desired service.

I, the undersigned, understand the office procedures and policies as noted above. I have had a chance to have all my questions answered in my satisfaction and agree to abide by the policies listed above.

Patient Name (Print) _____ Date _____

Signature: _____

Your Privacy is Important to Us

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices of Malinski Dermatology. I hereby authorize, as indicated by my signature below, Malinski Dermatology to use and to disclose my PHI (Protected Health Information) for any necessary clinical, financial, and insurance purpose(s), as authorized in the Patient Consent Form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please Initial by your preferred means of communication:

_____ You may contact/leave a message at my ***home*** telephone number:_____

_____ You may contact/leave a message at my ***mobile*** telephone number:_____

_____ You may contact/leave a message at my ***work*** telephone number:_____

_____ You may send me an *unencrypted email*:_____

Other:_____

Please list authorized person(s) with whom we may discuss your PHI in additional to custodial and legal guardians:

1. _____ Date ADDED / REMOVED:_____
   Name/Relationship to Patient
2. _____ Date ADDED / REMOVED:_____
   Name/Relationship to Patient
3. _____ Date ADDED / REMOVED:_____
   Name/Relationship to Patient

** For Internal/Office Use Only**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgment
- Other:_____

Staff Initials:_____