64231 Hwy. 434
Lacombe, LA 70445
Phone: (985) 202-3376 / Fax: 985-882-2686

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 Address:____ *(Statements and billing only, no marketing material will be sent)*

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

64231 HWY 434
Lacombe, LA 70445

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 $100.00.***

LATE ARRIVALS

As a 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 POLICIES

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 protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

____

Print Name (Circle One: Patient / Parent / Legal Guardian)

Address:______________________________ City:________________ State:_______ Zip:________

Signature:____________________________________ Date:____________________________

Email Address:**____________________________ (Statements and billing Only, No marketing material will be sent**)

Emergency Contact:______________________ Phone:______________ Relationship to Patient:________

Please check your preferred means of communication:
Pt. Initials

_____ You may contact me/leave message at my home / work / mobile (Circle) telephone number: __________

_____ You may send me an unencrypted email at: ____

_____ Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians

1. ________________________________ Date Added / Removed: ________________________
   Name / Relationship
2. ________________________________ Date Added / Removed: ________________________
   Name / Relationship
3. ________________________________ Date Added / Removed: ________________________
   Name / Relationship

* * *

For Office Use Only:

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

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other (Please Specify) ______________________________________ Staff Initials ________

By signing this form, I give Malinski Dermatology permission to debit/charge my account. This is permission for keeping the below credit card on file for the authorized cardholder.

Patient Name (First, Middle, Last):____

Billing Address:______________________________ Phone:_______________________

City, State, Zip:______________________________ Email:________________________

Card Type:	**VISA**	**MASTERCARD**	**DISCOVER**	**AMEX**
Cardholder Name:	____			
Card #:	____			
Expiration Date:	____			
CCV:	_________________________			

I authorize the above named business to charge the credit card indicated in this authorization form. I certify that I am an authorized user of this credit card and that I will not dispute the payment to my credit card company. I understand that this authorization will remain in effect until I cancel it in writing.

A 3% credit card fee will be applied to all credit card transactions, you may avoid this fee by keeping a debit card or HSA on file.

Patient Name (Print:)__________________________________ Date:_________________

Patient Signature:____

Malinski Dermatology
64231 HWY 434
Lacombe, LA 70445
P: (985) 202-3376 F: (985) 882-2686