

# HAYDEL DERMATOLOGY PATIENT INFORMATION

PLEASE PRINT

Referring Physician: \_\_\_\_\_

PATIENT:

\_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

\_\_\_\_\_  
ADDRESS APT # CITY STATE ZIP

\_\_\_\_\_  
HOME PHONE CELL PHONE WORK PHONE SEX

\_\_\_\_\_  
**DATE OF BIRTH** SOCIAL SECURITY NO. DRIVER'S LICENSE NO.

\_\_\_\_\_  
EMAIL ADDRESS MARITAL STATUS

Emergency Contact or Nearest Friend or Relative (Not Living with Patient):

\_\_\_\_\_  
NAME RELATIONSHIP PHONE

Primary Insurance:

\_\_\_\_\_  
INSURANCE PLAN NAME INSURANCE ID # GROUP #

INSURED:

\_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

\_\_\_\_\_  
ADDRESS APT # CITY STATE ZIP

\_\_\_\_\_  
HOME PHONE **\*DATE OF BIRTH\*** SEX SOCIAL SECURITY # MARITAL STATUS

\_\_\_\_\_  
**RELATIONSHIP TO PATIENT**

Is there another Health Benefit Plan? \_\_\_\_\_

Secondary Insurance:

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Plan Name \_\_\_\_\_ SS # \_\_\_\_\_

I am interested in learning more about:

Skin Care Products  Visia Skin Analysis  Cosmetic Procedures (Botox, Fillers, Laser)  Laser Services

\_\_\_\_\_  
SIGNATURE OF PERSON REQUESTING CARE DATE

## PATIENT AUTHORIZATION

I consent to treatment, **including biopsies**, necessary for the care of the below named patient. **I understand that I will receive a separate bill from Dr. T. Nicotri (a skin pathologist) for each skin specimen processed. (By law, Dr. Haydel is required to send skin specimens to a pathologist for biopsies and surgeries.)**

I authorize the release of all medical records to the referring and family physicians. I allow fax transmittal of my medical records, if necessary.

**I acknowledge full financial responsibility for services rendered by Haydel Dermatology, Dr. Sarah Alexander Haydel. I understand I have 30 days after insurance pays to pay in full or make arrangements. I also understand that if surgery is needed, I am required to pay half the cost upon completion of the surgery. If my insurance company reimburses at a higher rate, Haydel Dermatology will provide a refund. (This DOES NOT APPLY to Medicare or any Medicare related insurance plan).**

I have read and fully understand the above consent for treatment, **biopsies**, financial responsibility, release of medical information, insurance authorization, and Patient Surety Agreement.

Date \_\_\_\_\_ Signature \_\_\_\_\_

## PATIENT CONSENT AND ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Haydel Dermatology, Inc., creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must:  
agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information;  
and  
agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which may have been previously agreed upon.

\_\_\_\_\_  
PATIENT'S NAME PRINTED

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

\_\_\_\_\_  
SOCIAL SECURITY # (FOR IDENTIFICATION PURPOSES ONLY)

\_\_\_\_\_  
WITNESS (OPTIONAL)

\_\_\_\_\_  
DATE

# HAYDEL DERMATOLOGY MEDICAL HISTORY

Patient: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  Yes  No If yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

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)

| <b>Lungs:</b>          | <b>YES</b>               | <b>NO</b>                | <b>Other Systemic:</b>             | <b>YES</b>               | <b>NO</b>                |
|------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|
| Bronchitis             | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema              | <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst/hunger            | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                 | <input type="checkbox"/> | <input type="checkbox"/> | Amputation                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of Breath    | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid                            | <input type="checkbox"/> | <input type="checkbox"/> |
|                        |                          |                          | Kidney                             | <input type="checkbox"/> | <input type="checkbox"/> |
|                        |                          |                          | Dialysis                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Cardiovascular:</b> | <b>YES</b>               | <b>NO</b>                | Gastrointestinal                   | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure    | <input type="checkbox"/> | <input type="checkbox"/> | Stomach absorptive disorder        | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain             | <input type="checkbox"/> | <input type="checkbox"/> | Chron's Disease/Ulcerative Colitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack           | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/Joint Deformity          | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur           | <input type="checkbox"/> | <input type="checkbox"/> | Arthralgia                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular Heartbeat    | <input type="checkbox"/> | <input type="checkbox"/> | Limited Motion                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Inflammation of vein   | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood clots            | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions, Epilepsy or Seizures  | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker              | <input type="checkbox"/> | <input type="checkbox"/> | Fainting                           | <input type="checkbox"/> | <input type="checkbox"/> |

Have you had or have you been exposed to HIV (AIDS)?  Yes  No

List any other diseases or conditions: \_\_\_\_\_

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

| <b>Skin:</b>   | <b>YES</b>                                 | <b>NO</b>  |
|--|--|--|
| Do you have a history of fever blisters?             | <input type="checkbox"/>                   | <input type="checkbox"/>   |
| Have you ever had skin cancer?                       | <input type="checkbox"/>                   | <input type="checkbox"/>   |
| Has anyone in you family had melanoma?               | <input type="checkbox"/>                   | <input type="checkbox"/>   |
| Do you have a history of any specific skin diseases? | <input type="checkbox"/>                   | <input type="checkbox"/>   |
| Have you ever taken Accutane?                        | <input type="checkbox"/>                   | <input type="checkbox"/>   |
| Do you develop keloids (scars) after surgery?        | <input type="checkbox"/>                   | <input type="checkbox"/>   |
| Do you bleed easily?                                 | <input type="checkbox"/>                   | <input type="checkbox"/>   |
| Do you develop skin rashes in reaction to            | <input type="checkbox"/> Medications       | <input type="checkbox"/> Food <input type="checkbox"/> Environment <input type="checkbox"/> Bandages |
|  | <input type="checkbox"/> Topical Neosporin | <input type="checkbox"/> 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? \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Due date: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is your occupation? \_\_\_\_\_

**Do you have a history or tendency of fainting during medical procedures?**  YES  NO

**CAN LAB TEST RESULTS BE LEFT ON YOUR ANSWERING MACHINE?**  YES  NO

**(ALL BIOPSIES ARE SENT TO DR. T. NICOTRI, A SKIN PATHOLOGIST; SEPARATE CHARGES WILL BE INCURRED FROM HIS OFFICE)**

## Cosmetic Inquiry:

I would be interested in more information on the following: (Please check all that apply)

BOTOX  Chemical Peel  Restylane  Microdermabrasion  Skin care products  
 Leg Vein Therapy  Laser Hair Removal  Vascular Laser Treatment

Completed by:  Patient  Medical Assistant \_\_\_\_\_ (Initials)



1026 SCHOOL STREET  
HOUMA, LA 70360

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## IMPORTANT SUMMARY NOTICE OF THE PRIVACY OF YOUR HEALTH INFORMATION

### (KEEP THIS FOR YOUR RECORDS)

Your Privacy is important to us. We record information about you so that we may provide you with quality medical care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regards to your health information, as well as we may use your health information, and how we must protect the confidentiality of your health information. This is a summary of the more detailed information contained in our Notice of Privacy Practices.

Your rights include:

- A right to amend your health information
- A right to request restrictions on what information we use or how we disclose your health information.
- A right to see an accounting of certain disclosures we have made of your health information
- A right to obtain access to your health information with limited exceptions. (A written, notarized request, an appointment for access, appropriate advance notice, and a cost based fee for expenses is delineated by law).
- A right to receive a paper copy of our Notice of Privacy Practices.

These rights do have special restrictions and you may request and read the full Notice at any time.

We may use your health information and/or records to:

- Plan for your care and help your health care providers communicate and work together for you.
- Submit bills to pay for your care.
- Help health care payers or medical insurance companies make sure services were provided.
- Help improve the quality of your health care.
- Disclose information to certain officials or organizations as required by law.

Everyone who is trained or has access to your information is bound by your confidentiality requirements, and signs a confidentiality agreement. We encourage you to read the notice and contact us if you need more information.

I have received the Notice of Privacy Practices at Haydel Dermatology.

Signature \_\_\_\_\_ Date \_\_\_\_\_