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)

Lungs:	**YES**	**NO**
Bronchitis	□	□
Emphysema	□	□
Asthma	□	□
Shortness of Breath	□	□

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

Other Systemic:	**YES**	**NO**
Diabetes	□	□
Excessive thirst/hunger	□	□
Amputation	□	□
Thyroid	□	□
Kidney	□	□
Dialysis	□	□
Gastrointestinal	□	□
Stomach absorptive disorder	□	□
Chron's Disease/Ulcerative Colitis	□	□
Arthritis/Joint Deformity	□	□
Arthralgia	□	□
Limited Motion	□	□
Artificial Joint	□	□
Convulsions, Epilepsy or Seizures	□	□
Fainting	□	□

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: _______________________________

Skin:	**YES**	**NO**
Do you have a history of fever blisters?	□	□
Have you ever had skin cancer?	□	□
Has anyone in you family had melanoma?	□	□
Do you have a history of any specific skin diseases?	□	□
Have you ever taken Accutane?	□	□
Do you develop keloids (scars) after surgery?	□	□
Do you bleed easily?	□	□

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? ________________________________

(**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)

578 VALHI BLVD
HOUMA, LA 70360

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________________________