

**NEW PATIENT INTAKE INFORMATION**

Your Name (Last, First) \_\_\_\_\_, \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender (please circle): M F

Address: \_\_\_\_\_ Apartment # \_\_\_\_\_ or N/A

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Best number to leave any confidential information regarding your treatment and messages: (please circle) Cell Home Work

E-mail address: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Name and number of the person(s) we may speak to regarding your health (spouse, child, etc.): \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Number: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Name on Card: \_\_\_\_\_ Other info: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Heart Disease (Heart Attack, etc.)?	NO	YES	(If YES, explain) _____
Neurological Disease (Seizures, Headaches)?	NO	YES	(If YES, explain) _____
Lung Disease (COPD, Asthma, etc.)?	NO	YES	(If YES, explain) _____
Liver or Kidney Disease (Hepatitis, etc.)?	NO	YES	(If YES, explain) _____
Cancer (Leukemia, Lymphoma)?	NO	YES	(If YES, explain) _____
Digestive Problems (IBS, etc.)?	NO	YES	(If YES, explain) _____
Do you have Hypertension ?	NO	YES	(If YES, explain) _____
Trauma (serious car accidents, injuries, etc.)?	NO	YES	(If YES, explain) _____
Do you have Diabetes or "pre-diabetes"?	NO	YES	(If YES, explain) _____
Immunosuppression (HIV, AIDS, etc.)?	NO	YES	(If YES, explain) _____
Endocrine Disorder (Thyroid Disease, etc.)?	NO	YES	(If YES, explain) _____
Have you ever had Surgery?	NO	YES	(If YES, explain) _____
Do you have any OTHER medical problems?	NO	YES	(If YES, explain) _____





**----- HIPPA PATIENT CONSENT -----**

Kirby Dermatology, A Medical Corporation, is committed to protecting the privacy of your medical information! The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that governs the use and disclosure of a person's health information. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The Notice contains a "Patient Rights" section describing your rights under the law. The following statements cover the basics of your rights as a patient under HIPAA:

- Protected health information may be disclosed for treatment, payment, or health care operations.
- We have a "Notice of Privacy Practices" and you have the right to review a detailed copy of our Notice before signing this HIPPA Patient Consent.
- Our "Notice of Privacy Practices" is clearly posted in our office (it's the blue and white poster on the wall; handouts are also available and can be obtained from an office staff member).
- We reserve the right to change the terms of our "Notice of Privacy Practices".
- If we change our Notice, you may obtain a revised copy by contacting our office.
- You have the right to restrict the uses of your protected health information.
- You may revoke this HIPPA Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Additionally, It is the policy of Kirby Dermatology, A Medical Corporation, to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice. We may also send you other communications informing you of changes to office policy, new technology and specials that you might find valuable or informative. That said, contact would only come directly from us; We will never sell or trade your private information including phone numbers, e-mail address or home/work addresses.

By signing the next page of this document, you certify that you have read our HIPPA Patient Consent and have had the opportunity to review a more detailed version if so desired. Your signature also signifies that you agree with the above statements and this policy. You also agree to authorize the release of medical information to your primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. We provide this form and information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**----- FINANCIAL RESPONSIBILITY POLICY -----**

I understand that payment is required for all services rendered. I agree to pay any unmet deductible, non-covered services, and co-payment. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. Kirby Dermatology, A Medical Corporation, is not responsible for knowing my insurance plan, what it covers, or the deductible requirements. I understand that Kirby Dermatology accepts payment in the form of cash, check, or credit card. In the event that my account must be turned over to collections, I understand that a \$100.00 collection fee will be added to my account balance. My printed name and signature below signifies my understanding and willingness to comply with this policy and to authorize payment of medical benefits to Kirby Dermatology, A Medical Corporation.

**----- MISSED / LATE APPOINTMENT POLICY -----**

I understand that Dr. Kirby strives to treat all patients at their scheduled times and that I must provide at least 24 hours notice if I need to reschedule or am unable to make my appointment. I understand that if I frequently miss appointments or am frequently late for appointments then a credit card may be required to book future appointments. I also understand that a deposit will be required to book appointments for cosmetic services.

**----- CONSENT FOR EXAMINATION AND TREATMENT -----**

I hereby authorize Kirby Dermatology, A Medical Corporation, Dr. William Kirby, his associate(s), and/or his staff to examine me (or the patient named on this form) and to administer any and all treatment that the doctor or his associate(s) deem necessary.

*My printed name & signature below certify that I have provided complete and accurate contact & medical information and that I have read, fully understand & completely agree with the HIPPA Patient Consent, Financial Responsibility and Missed / Late Appointment Policies contained in this document and I agree to Examination and Treatment.*

<b>✘</b> _____	<b>✘</b> _____
<b>Printed Name of Patient (or legal guardian)</b>	<b>Date</b>
<b>✘</b> _____	
<b>Signature of Patient (or legal guardian)</b>	