OMNI
DERMATOLOGY

Patient Name
Last:_____First:_____ MI:_____
Parent(s)/Guardian(s) Name: Not Applicable ☐
Last:_____ First: _____ Relation:_____

Last:_____ First: _____ Relation:_____

Social Security #: Date of Birth: Sex: M☐ F☐

Address:
Street:_____ Apt/Unit #:_____

City:_____ State: _____ Zip Code: _____

Phone Numbers:

Home:_____ Cell: _____

Email: _____

Confirm appointments by: Text ☐ Email ☐ Phone ☐

Demographics: Marital Status: Divorced☐ Widowed☐

Language:_____ Race:_____ Married☐ Single☐

Guarantor Information: (Parent/Guardian and/or to whom billing statements are sent)

****Check this box if it is the same as patients information ☐****

Full Name:_____ Date of Birth:_____

Street:_____ Apt/Unit #:_____

City:_____ State: _____ Zip Code: _____

Phone:_____ Relation:_____

Emergency Contact:

Full Name:_____ Relation:_____

Home Phone: _____ Cell Phone:_____

Billing and Insurance Information ***only fill out if you are **NOT** the primary insurance holder***

	Primary	***Secondary***	***Additional***
Policy Holder Name			
Policy/ID Number			
Group Number			
Policy Holder DOB			

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PATIENT MEDICAL HISTORY

Patient Name: _____

Doctors/Specialists (Please list doctors, first & last name, who need to be informed about your appointments)

_____

Reason for Visit: _____

Pharmacy Name & Crossroads: _____

Medications: _____

Allergies: _____

Have you received a shingles Vaccine? ❒ Yes ❒ No ❒ Unsure

Are you pregnant? ❒ Yes ❒ No If yes, how far along are you? _____

Are you positive for: HIV ❒ Yes ❒ No AIDS ❒ Yes ❒ No

Are you positive for: Hepatitis ❒ Yes ❒ No *If yes, please specify which type* _____

Past Medical History: Please circle your answers *If all are Negative then check here: _____

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ COPD
- ☐ Cancer: _____
- ☐ Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Blood Clots in Lungs
- ☐ Reflux Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other: _____

Surgical History with Month & Year:

_____

Family History☐Rashes☐Skin Cancer☐Melanoma If yes, then whom: _____

Social History: Please circle your answers

Do you Smoke: Former☐Current☐Never☐

If yes how much: Less than 1/4 PPD☐1/4 PPD☐1/2 PPD☐1 PPD☐More☐

Do you drink Alcohol: Never☐Occasionally☐Moderately☐Heavily☐

Are you: Single☐ Married☐ Divorced☐ Widowed☐

How long have you lived in AZ: _____

Do you use Sun block regularly? Yes☐No☐

Have you traveled outside of the U.S. recently? Yes☐No☐If yes, where did you travel to? _____

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PATIENT MEDICAL HISTORY (CONT'D)

Please Circle Any Positives:

**If all of the following are negative please check here _____

Review of Symptoms:

General: Fever Chills Nausea Fatigue

Skin: Itching Burning Tenderness Hair Loss Nail Problems

Eyes: Itching Redness Dryness

Mouth: Ulcers Rash Pain

Nose: Sinus Problems Nose Bleeds

Pulmonary: Asthma Shortness of Breath Coughing Blood

Cardiovascular: Leg Swelling

Genitourinary: Abnormal Discharge Pain with Urination

Musculoskeletal: Weakness Joint Pain Joint Swelling

Neurological: Numbness Tingling Headaches

Endocrine: Change in Voice Heat or Cold Intolerance Weight Gain/Loss

Psychological: Depression Anxiety High Stress

Hematologic: Anemia Bleeding Disorder Taking Blood Thinners

Allergic/Immunologic: Seasonal Allergies Autoimmune Disease

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and Disclosure of Your Health Information in Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operation. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have the right to review the Notice of Privacy Practices prior to signing this consent. Omni Dermatology and its providers reserve the right to revise this Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Omni Dermatology Privacy Officer at 4840 E Indian School Rd Ste 102, Phoenix, AZ 85018.

With my consent, Omni Dermatology and it providers and staff may call my home or to other designated location and leave a message on a voice mail or in person in reference to any items that assist the practice in carry out TPO; such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Omni Dermatology and its providers and staff may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

By signing this form, I am consenting to Omni Dermatology's providers and staff to use and disclosure of my Personal Health Information to carry out treatment, payment and healthcare operations. I have also read the Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Omni Dermatology may decline to provide treatment to me.

I herby acknowledge that I have been presented with a copy of Omni Dermatology Notice of Privacy Practice

_____ _____ _____

Patient's Name Signature Date

OMNI DERMATOLOGY

HIPPA CONSENT TO LEAVE MESSAGE

Patient Name: _____ DOB: _____

I wish to be called at home ☐ other ☐ (check all that apply) regarding my care and follow up. The best telephone numbers(s) to reach me are:

Home Phone: _____Other Phone: _____

I do ☐ I do not ☐ want relevant medical information (i.e. lab results, biopsy results) on my answering machine or voice mail.

I do ☐ I do not ☐ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

_____

_____

_____

_____

_____ _____

Patient Signature Date

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PHOTOGRAPHY PERMIT

I hereby authorize the appropriate personnel of Omni Dermatology and its providers and staff to take digital pictures of my skin condition.

I hereby state that it has been fully explained to me that said pictures are taken for the

purpose of medical record documentation, location for treatment options, and for the showing to the duly licensed physicians, nurse practitioners, and authorized paramedical personnel should treatment be needed in the future. These photos are a vital part of your chart and are HIPAA compliant.

I further state that at the time of the execution of the consent, that I am fully aware of the pictures to be taken and the uses, as above described, to which they are to be put, and that all questions with respect to the taking of the pictures and the use there of have been fully explained to me and to my complete satisfaction by personnel of Omni Dermatology.

_____ _____

Signature Date

MEDICATION HISTORY AUTHORITY

We are implementing a new Electronic Medical Records (EMR) program that will **automatically import your medication history from third party sources (i.e. pharmacies)**. In order to transfer your current and past medications to the new system we must have your authority.

By signing below I hereby certify Omni Dermatology to transfer my medication history.

_____ _____

Signature Date

_____

Patient Name (printed)