Patient Information as of _____ (enter today's date)

Please Print Legibly & Fill In or Correct Fields

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Pharmacy _____

Email: _____

Primary Care Provider: _____ Referred by: _____

Age _____ Birthdate ___/___/___ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

If < age 18: Mother: _____ Father: _____ Phone:_____

Patient's Employer Occupation _____

Work Phone _____ Ext: _____

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Co _____

Policy # _____ Group # _____ Ins. Phone _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Co _____

Policy # _____ Group # _____ Ins. Phone _____

Insured: Name _____ DOB _____ Employer _____

Health Care Information may be released to (Next of Kin): _____

Signature _____ **Date** _____

MEDICAL HISTORY

Name: **Date of Birth**: **Date:**

History of Present Illness (Reason for Visit): _____

Location: _____ Worse When: _____
Duration: _____ Better When: _____
Severity: _____ Treatment: _____

Review of Systems (check if a current problem)

_____ Eyes _____ Musculoskeletal
_____ ENT & Mouth _____ Neurological
_____ Respiratory _____ Psychiatric
_____ Gastrointestinal _____ Endocrine (diabetes, thyroid)
_____ Genitourinary _____ Cardiovascular
_____ Hematologic/Lymphatic _____ Allergic/Immunologic
_____ Skin

Medical History	Self	Father	Mother	Children	Siblings
Melanoma	_____	_____	_____	_____	_____
Skin Cancer	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____
Psoriasis	_____	_____	_____	_____	_____
Lupus	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
HIV/AIDS	_____	_____	_____	_____	_____
Hayfever	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Migraine	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____
Bowel Disease	_____	_____	_____	_____	_____

Current Meds _____

Drug Allergies _____

Where did you grow up? _____
How many blistering sunburns have you had? _____
Are you exposed to toxic chemicals in your job or hobbies? _____
If so, what are they? _____
Have you traveled outside the U.S. in the last 2 years? _____
If so, where? _____

Narra Dermatology and Aesthetics Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your obligation and your rights.

Protecting your Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will be properly disclosed or released.

Collecting Protected Healthcare Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for you copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

Narra Dermatology and Aesthetics
Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Narra Dermatology. The statement of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Narra Dermatology reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse Only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
An Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other:	☐ **YES**	☐ **NO**
Name of patient (please print):_____		
Patient Signature:_____		
Personal Representative's signature:_____		
Representative's Telephone Number:_____ Date:_____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:_____**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	