

SENER DERMATOLOGY - PATIENT DATA SHEET – PLEASE PRINT

*****Please Note*** If this form is not filled out completely, we will not be able to submit to your insurance.**

UPDATE INITIALS

Today's Date: ____/____/____ Patient Date Of Birth: ____/____/____

Patient Name: _____

FIRST

M.I

LAST

Address: _____

STREET

CITY

STATE

ZIP CODE

Home Number: _____ Work Number: _____ Cell Number: _____

**** MAY WE LEAVE MESSAGES WITH MEDICAL INFORMATION AT THE NUMBERS LISTED ABOVE? Yes No ****

Gender: Male Female

Marital Status: D M S W

SSN# _____

Email address: _____

Occupation: _____

Employer: _____

Emergency Contact & relation to patient: _____ Contact Number: _____

Any family members who are patients here? If so, please list: _____

Who is responsible for this account? _____ Contact Number(s): _____

Address: _____

STREET

CITY

STATE

ZIP CODE

Please list the name(s) and phone number(s) of all those that you give us permission to speak to regarding your care here: _____

MEDICAL HISTORY

Are you allergic to any medications? Yes No

Any other Allergies? Yes No

If yes, please list: _____

If yes, please list: _____

Are you taking any medications? (Prescribed/Over the Counter) Yes No If yes, please list: _____

What is your preferred Pharmacy? _____ Location: _____

Who is your Primary Care Physician? _____ Contact Number: _____

Are you seeing any other Physicians at this time? If so, please list: _____

Do you or any family member have a history of skin cancer? If so, who and what kind? _____

General medical history:

DATE

Relationship to Patient: _____
SIGNATURE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

USES AND DISCLOSURES OF HEALTH INFORMATION TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Sender Dermatology uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

- Sharing test results with other health care provider for confirmation of diagnosis;
- Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide;
- Reviewing information as part of our quality improvement program.

Other Uses and Disclosures

Sender Dermatology may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Provide you with information related to your health;
- Contacting you regarding appointments, information about treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign in sheet, etc.);
- Compliance with all laws (including reports of suspected abuse, neglect or violence);
- Providing certain specified information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
- Public health activities when requested by public health authority or the FDA;
- Responding to health oversight agencies;
- Responding to court or administrative tribunal orders, subpoenas, discover request or other lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans' affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to public or private disaster relief agencies;
- Informing a family member, other relative or close personal friend when: Information is relevant to the individual's involvement with your care;
- To assist in your health care (e.g. pick-up prescription or other documents, note follow up care instructions, etc.).

Authorization for Other Uses

Sender Dermatology will make other uses or disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice you may revoke your authorization.

Your Rights Regarding the Privacy of your Health Information

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses or disclosures. However, Sender Dermatology is not obliged to agree to requested restrictions.
- Receive confidential communications of protected health information.
- Inspect and copy your protected health information with some limited exceptions.
- Amend your health information.
- Receive an accounting of disclosures of your health information.
- Obtain a copy of this notice.

Sender Dermatology Regarding the Privacy of your Health Information

Subject to limitations outlined by law, Sender Dermatology has certain duties related to your protected health information, including:

- Sender Dermatology is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Sender Dermatology is required to abide by the terms of the privacy notice that is currently in effect.
- Sender Dermatology reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacted Sender Dermatology or the Secretary for the Department of Health and Human Services. NO individual will be retaliated against for filing a complaint.

Acknowledgement

I acknowledge that I received a copy of this notice regarding the use and disclosures of my health information.

X: _____ / _____ / _____
Signature **Printed Name** **Date**