Saratoga Dermatology
Adult New Patient Information

Date: _____

Patient Name: (Last) _____(First)_____(MI)_____

Date of Birth: _____Age:_____ Sex: _____M _____F

Address: _____

City:_____State:_____Zip Code_____

Home Phone # _____ Work Phone #_____ Cell #_____

Email address: _____**Do you have access to our patient portal? Yes No**
If no, please request a sign on from our front staff.

Do you have communication needs that we should know about? (exp. Hard of hearing, deaf, impaired vision, etc.)

Yes _____ No _____ If yes, explain_____

What is your primary language: _____Secondary: _____

Race: White ( ) Black/African American ( ) Asian ( ) Other ( ) Declined to Specify ( )

Ethnicity: Hispanic ( ) Not Hispanic Latino ( ) Declined to Specify ( )

Emergency contact if we are unable to reach you: Name: _____

Phone #: _____Relationship to patient: _____

Primary Care Physicians Name: _____

Telephone Number:_____Address:_____

Pharmacy: _____Telephone #_____

Address: _____

Pharmacy Coverage if different than Medical Coverage:_____

Skin Concerns:

What skin concern brings you here today?_____

What additional skin concerns do you have? _____

Do you have a history of skin cancer? Yes No
If yes, what type and what location? _____

Patient Name: _____ DOB: _____ Date: _____

HEALTH HISTORY

List all current medications and doses: _____

_____

_____

Do you have any allergies to medications: Yes____ No _____

If yes, what medications? _____

Have you had a flu shot? Yes_____ No _____ If yes, when? _____

Do you have any chronic illnesses? Yes_____ No_____

If yes, please check all Medical Problems you have had:

	Anemia		Diabetes		Kidney Disease
	Anxiety		Drug Addiction		Kidney Stones
	Acne		Eczema		Liver Disease
	Allergies-Seasonal		Epilepsy or Seizure Disorder		Lung Disease
	Alzheimer's Disease/Dementia		Esophagitis		Lupus
	Arthritis		Fibromyalgia		Mental Illness
	Asthma		GERD		Migraines
	Atrial Fibrillation		HIV		Multiple Sclerosis (MS)
	Blood Disorder		Heart Attack		Parkinson's Disease
	Bronchitis		Heart Disease		Peripheral Vascular Disease
	Cancer		Herpes/Cold Sores		Psoriasis
	COPD		Hyperlipidemia		Stroke
	Depression		Hypertension		Sinus Disease
	Diverticulosis/Crohns/Colitis				Thyroid Disease
	Other:				Tuberculosis

GYN & OB HX:
Are you currently pregnant? Yes No
If no, are you planning on becoming pregnant? Yes No
Are you currently breast feeding? Yes No
Total # of pregnancies_____
Total # of children_____

List and date all surgeries and/or hospitalizations over the past two years including any joint replacements:_____

Do you have a pace maker or defibrillator? Yes No

Name: **DOB:** **Date:**

SOCIAL/PERSONAL HISTORY:

Highest level of education attained: _____ Marital Status: ( ) single ( ) married ( ) divorced ( ) widowed

Occupation: _____ Are you currently working? Yes _____ No_____

Children: _____

Do you smoke? Yes____ No_____ If yes, amount per day: _____

Did you previously smoke? Yes____ No_____ If yes, amount per day: _____

Do you drink alcohol? Yes____ No_____ If yes, amount per day: _____

Do you take illicit drugs? Yes____ No_____ If yes, explain: _____

FAMILY MEDICAL HISTORY:

Please circle below. If you answer yes, please state the relationship of the family member.

Allergies – Seasonal	Yes	No	_____
Asthma	Yes	No	_____
Eczema	Yes	No	_____
Heart Disease	Yes	No	_____
Psoriasis	Yes	No	_____
Skin Cancer	Yes	No	_____

REVIEW OF SYSTEMS

PLEASE CIRCLE IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS

CONSTITUTIONAL: Fever, Chills, Fatigue

EYES: Abnormal Vision

EARS, NOSE, MOUTH & THROAT: Hoarseness, Sore Throat, Hearing Problems

CARDIOVASCULAR: Chest Pain, Shortness of Breath on Exertion, Palpitations

GASTROINTESTINAL: Diarrhea, Nausea, Vomiting

INTEGUMENTARY: Skin Rash, Persistent Itch, Other: _____

GENITOURINARY: Difficulty Urinating, Frequency of Urination, Burning Urination

MUSCULOSKELATAL: Joint pain, Muscle Pain, Stiffness, Swelling

RESPIRATORY: Cough, Shortness of Breath, Wheezing

NEUROLOGICAL: Headaches, Weakness

_____

Reviewed by:

NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please review it carefully*.

THE INFORMATION THIS POLICY APPLIES TO

There are laws that protect information about your health care that identifies or can be used to identify you and is held by entities such as Saratoga Dermatology, P.C. This is called Protected Health Information or PHI under federal law. We refer to this as health information in this notice.

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the health information we share
- Get a list of those with whom we've shared your health information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
- Be provided with notice if there is a breach involving your health information

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your health information
- Raise funds

OUR USES AND DISCLOSURES

In order to help us provide you with quality and effective medical care, we may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Offer you information about additional information or services you may want to use
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request in all instances, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the bottom of the page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your health information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share health information with your family, close friends, or others involved in your care
- Share health information in a disaster relief situation
- Include some of your health information in a hospital directory
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your health information if we believe it is in your best interest. We may also share your health information when needed to lessen a serious and imminent threat to health or safety*

In these cases we never share your health information with other parties unless you give us written permission:

- Marketing purposes
- Sale of your health information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, provide you with information about other services we offer, reminders for preventive care and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your health information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your health information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

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Help with public health and safety issues

- We can share certain health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety

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Do research

- We can use or share your health information for health research.

Comply with the law

- We will share health information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

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Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your health information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date 5/1/2019

This Notice of Privacy Practices applies to the following organizations.
Saratoga Dermatology, PC
54 Seward Street
Saratoga Springs, NY 12866