

(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Full Name (as listed on insurance card):** \_\_\_\_\_

Address: \_\_\_\_\_

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

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

Any restrictions for contacting you?  No  Yes

E-mail: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Other: \_\_\_\_\_

**Language** (circle one): English Spanish Other

**Race** (circle one): Caucasian African-American Hispanic Asian Other

**Ethnicity** (circle one): Hispanic or Latino Not Hispanic or Latino

**Primary Insurance Policy Holder Name** (i.e., parent, spouse) \_\_\_\_\_

Primary Policy Holder DOB: \_\_\_\_\_ Primary Policy Holder SS #: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Parent / Guardian:** (if accompanying minor on visit)

Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

I Understand that office visit charges are payable on the day service is rendered. I authorize **Franks Dermatology** to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

I understand that my contract is between **Franks Dermatology** and myself.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Past Medical History - Please check all that apply**

- Arthritis
- Asthma
- Autoimmune Disease
- Breast Cancer
- Depression
- Diabetes
- Eczema
- Heart Disease
- Hepatitis
- High Blood Pressure
- Require Antibiotics before Surgery or teeth cleaning
- HIV
- Hives
- Melanoma
- Pregnant
- Skin Cancer
- Cancer (Other than skin)
- Skin Disease
- Stroke
- Thyroid Disorder
- Tuberculosis
- Ulcers
- Psoriasis
- HEP C

**Past Surgeries/Hospitalizations – Please list**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Family History – Please check all that apply**

- Skin Cancer
- Psoriasis
- Acne
- Eczema
- Melanoma

**Allergies: food, drug, or environmental:**

\_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Current Medications:**

Name	Dosage	Frequency

**Patient Social History – Please check one for each (Information required)**

- Tobacco non-user
- Current Tobacco Smoker
- Current Smokeless Tobacco
- Does Not Drink Alcohol
- Uses Alcohol Socially
- 1-4 Drinks per day
- 4+ Drinks per day



**Designation of Personal Representative  
(For Use and Disclosure of Health Information Only)**

The Health Insurance Portability Act of 10/995 (HIPPA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. This form indicates your desire to designate the listed individual(s) to be your personal representative for your health information. Your designation can be revoked at any time.

I understand, and hereby authorize the following person(s) to act as my personal representative with respect to decisions regarding the use and/or to act as my personal representative with respect to decisions regarding the use and/or disclosure of my health information. **You may discuss my medical care with:**

Representative's Name (please print)	Phone Number	Relationship to you

I understand that I may revoke this designation at any time by signing a revocation will not apply to the extent that person authorized to use or disclose my health information already noted in reliance on my previous designation.

I do not wish to assign a personal representative. **Do not discuss my medical care with anyone but me.**

**Acknowledgement of  
Notice of Privacy Practices**

This notice states how we use and/or disclose your health information and is available upon request.

Patient's Name (Please Print)	Date

Patient's Signature



## Financial Agreement

Thank you for choosing Franks Dermatology as your health care provider. The following is a statement of our financial policy which we require that you read and sign prior to any treatment or office visit.

1. Deductibles, co-pays and any uncovered services are due at the time of service.
2. Fifty percent (50%) of the balance is due if a payment plan is requested.
3. You will be considered self pay until a copy of insurance card and referral (if required) is provided.
4. We accept cash, checks and credit cards.
5. As a courtesy we will file your primary and secondary insurance claims, when supplied with the current insurance information.
6. Medicare – We accept assignment. You will be responsible for the deductible and/or 20% co-insurance if not covered by your supplemental policy.
7. HMO'S/PPO'S – Please bring your referral number and your co-pay when you come for an office visit. These are your HMO's rules not ours. (It is the patient's responsibility to get referrals for visits).
8. Minor – The adult accompanying the minor will be responsible for payment.

I have read and understand how my physician desires to be compensated for the care I receive and I agree to be bound by these terms.

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**Patient's Signature**

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**Parent/Guardian Signature (if minor)**

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**Date**

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**Date**



- Our office is in the Simmons Bank Plaza Building, Suite 320.  
**Due to construction and changing routes, we suggest using Google Maps, Apple Maps or Waze for the most current and best routes.**

**4220 N Rodney Parham Rd, Suite 320**

**Little Rock, AR 72212**

**501-246-1042**



