FRANKS DERMATOLOGY

(501) 246-1042

(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: _____

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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

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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

FRANKS DERMATOLOGY

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.

_____ _____

Patient's Signature **Parent/Guardian Signature (if minor)**

_____ _____

Date **Date**

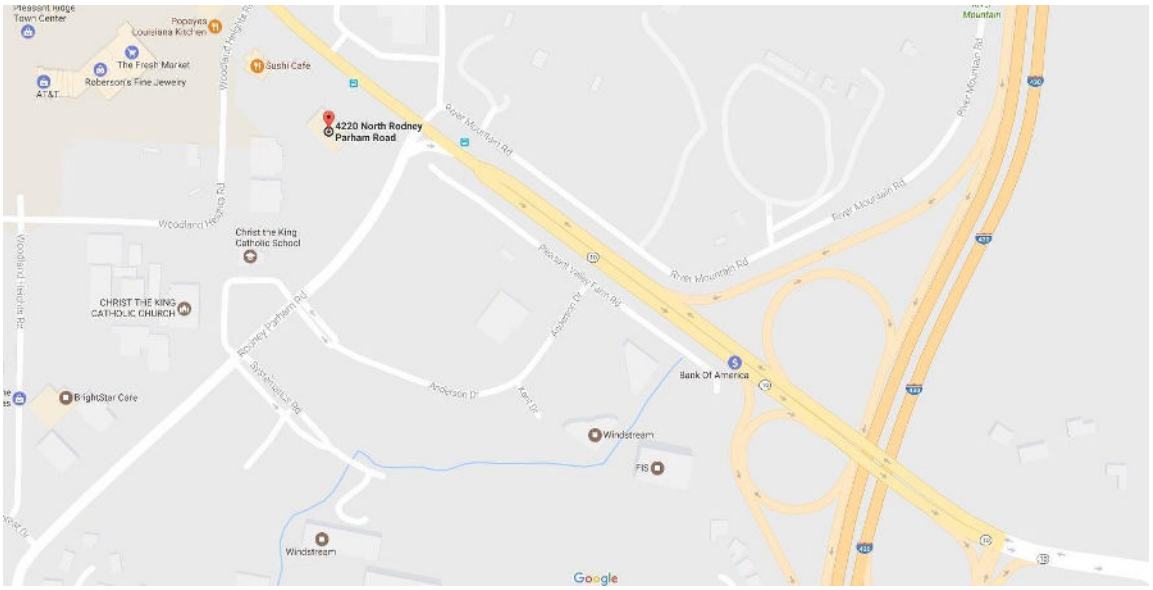
FRANKS DERMATOLOGY

- 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



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