ELITE DERMATOLOGY
1005 S. Telshor, Las Cruces NM 88011
2474 Indian Wells Rd, Alamogordo NM 88310
(575) 262-SKIN (7546)
(575) 888-CARE (2273)

NEW PATIENT INFORMATION

Last Name:	First Name:	Date of birth:
Mailing Address:		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Sex: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____	Race (please select): ☐ White ☐ Hispanic ☐ Other ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Decline to answer	Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐Voice ☐Text		If Voice, Please Select Preferred Number: ☐Home ☐Cell ☐Work
Email Address:		Social Security #:
Primary Care Provider:		Primary Care Provider Phone:
Preferred Pharmacy and location:		Preferred Language:

EMERGENCY CONTACT INFORMATION

Name	Phone	Access to Health Info?	Access to Financial Info?
		YES / NO	YES / NO
		YES / NO	YES / NO

PATIENT QUESTIONS

Have you ever had a bleeding disorder or problem with stopping bleeding? YES / NO
Have you ever had a problem with healing? YES / NO
Do you wear sunscreen? YES / NO
If so, please indicate SPF: _____
Do you tan in a tanning salon: YES / NO
Do you have a family history of Melanoma? YES / NO
If so, please indicate family member's relationship to patient: _____

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Do you have an allergy to latex? YES / NO
Do you have an allergy to lidocaine? YES / NO
Do you have any allergies to any food or drugs? YES / NO
If so, please list all allergies AND reactions:

Allergy	Reaction

Do you smoke? YES / NO
If so, how many packs per day? _____
If so, how long have you been smoking? _____
Are you a former smoker? YES / NO
If so, how many years did you smoke?
Do you drink alcohol? YES / NO
If so, how many drinks do you consume per day? _____
Do you use illicit drugs? YES / NO
If so, please indicate which illicit drugs you use and how often. _____
Are you sexually active? YES / NO
If so, do you have one partner or multiple partners? ONE / MULTIPLE
Are you able to drive during the day? YES / NO
Are you able to drive during the night? YES / NO
Do you exercise? YES / NO
If so, how often? DAILY / WEEKLY / MONTHLY
Do you drink caffeine? YES / NO
If so, how often? DAILY / WEEKLY / MONTHLY
What is your occupation? _____
Who is your employer? _____
Do you feel safe at home? YES / NO
Have you had your flu shot? YES / NO
If so, please indicate when: _____
Have you had your pneumonia vaccine? YES / NO
If so, please indicate when: _____
Have you had your Shingles vaccine? YES / NO
If so, please indicate when: _____

CURRENT LIST OF MEDICATIONS

Medication	Dosage	Frequency

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Please tell us the reason for your visit today:

_____

_____

PAST MEDICAL CONDITIONS

☐ NONE	☐ Elevated blood pressure	☐ Malignant lymphoma
☐ Anxiety disorder	☐ End-stage renal disease	☐ Malignant tumor of lung
☐ Arthritis	☐ Epilepsy	☐ Malignant tumor of breast
☐ Asthma	☐ Gastroesophageal reflux disease	☐ Malignant tumor of colon
☐ Atrial fibrillation	☐ History of hypertension	☐ Malignant tumor of prostate
☐ Benign prostatic hyperplasia	☐ Hearing loss	☐ Radiation therapy treatment management
☐ Cerebrovascular accident	☐ Human immunodeficiency virus infection	☐ Transplantation of bone marrow
☐ Chronic obstructive lung disease	☐ Hypercholesterolemia	☐ Other PLEASE SPECIFY: _____ _____ _____
☐ Coronary arteriosclerosis	☐ Hypothyroidism	
☐ Depressive disorder	☐ Inflammatory disease of liver	
☐ Diabetes mellitus	☐ Leukemia	
☐ Disease caused by 2019-nCoV		

PAST SURGICAL HISTORY

☐ NONE	☐ History of tubal ligation	☐ Lumpectomy of breast
☐ Abdominoperineal resection	☐ History of appendectomy	☐ Mastectomy of breast
☐ Bilateral replacement of knee	☐ History of cholecystectomy	☐ Mechanical heart valve replacement
☐ Biopsy of breast	☐ History of colectomy	☐ Oophorectomy
☐ Biopsy of prostate	☐ History of liver excision	☐ Pancreatectomy
☐ Coronary artery bypass	☐ History of percutaneous transluminal coronary angioplasty	☐ Prostatectomy
☐ Entire transplanted kidney	☐ History of tissue graft heart valve replacement	☐ Splenectomy
☐ Excision of basal cell carcinoma	☐ Hysterectomy	☐ Total replacement of joint
☐ Excision of melanoma	☐ Kidney biopsy	☐ Transplant of organ
☐ Excision of squamous cell carcinoma	☐ Low anterior resection of rectum	☐ Other PLEASE SPECIFY: _____ _____ _____
☐ History of colostomy		

SKIN CONDITIONS

☐ NONE	☐ Malignant melanoma
☐ Acne	☐ Psoriasis
☐ Actinic keratosis	☐ Rosacea
☐ Asteatosis cutis	☐ Squamous cell carcinoma
☐ Basal cell carcinoma of skin	☐ Sunburn
☐ Contact dermatitis	☐ Other PLEASE SPECIFY: _____ _____ _____ _____
☐ Eczema	
☐ Hives	
☐ Hair loss	
☐ Itching of scalp	

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AUTHORIZATION FOR ELITE DERMATOLOGY TO OBTAIN PAST MEDICAL HISTORY

Patient Last Name:	First Name:	Date of birth:
Mailing Address:		
City/State/Zip:		

Authorized individuals/entities:

(Please list any and all previous medical providers that may have relevant medical records):

Provider/Practice Name	Phone	Fax

To disclose protected health information to:

Elite Dermatology
1005 S. Telshor Ste A
Las Cruces, NM 88011
Phone (575) 262-7546
Fax (575) 888-2273

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Alamogordo, NM 88310
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Records to be disclosed:

☐ All medical records

☐ All medical records, with the exception of: _____

By signing this form, I understand the following: (1) if the entity authorized to receive my health information is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations; (2) I am not required to sign this form, but if I do not sign this form, it will not be considered valid, it will be returned to me and no information will be released by Elite Dermatology; (3) I may revoke this authorization at any time by notifying Elite Dermatology in writing; (4) if I do revoke this authorization, my revocation will have no effect on any actions Elite Dermatology took according to this authorization before Elite Dermatology received my revocation; and (5) it is my choice whether I sign this form and signing or not signing this authorization will not affect any payment, enrollment, or eligibility for benefit decisions made by Elite Dermatology.

I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by Elite Dermatology.

_____ _____

Signature of patient or personal representative Signature of Witness

ELITE DERMATOLOGY

GENERAL OFFICE POLICIES

Elite Dermatology is committed to providing the highest quality care in the most positive, efficient environment. Every patient, including you, deserves our undivided attention. To accomplish this goal, we find it necessary for patients and staff to follow some simple office policies.

1. Please arrive on time for your appointments. If you find that you may arrive late, please contact our office to confirm you can be worked in after your scheduled appointment time.

2. If you find it necessary to reschedule, please do so at least 48-hours prior to your appointment time. We may find it necessary to charge your account 35.00 for a missed appointment if you do not provide 48-hours notice.

3. To process your refill requests timely, we ask that you follow these steps:

   a. Routine prescription refills require 48-hours to approve. Please notify our office at least two days in advance so your refill is ready at the pharmacy when you need it

   b. For existing prescription refills, please contact your pharmacy first, even if you are out of refills. Your pharmacy will contact us.

   c. For problems with a new or existing prescription, contact our office. You will be routed to the appropriate line/extension. Please leave a message on the voice mail and your message will be attended to within 48-hours. This line is monitored throughout the day

   d. For problems with any prescription that is of an urgent need and cannot wait, please let the front office know at the time of your call that you do not want to be transferred on the call. You will be accommodated if it is an urgent request. While we understand the time sensitive nature of refilling prescriptions, we ask that you limit urgent immediate prescription issue requests to those that are actually urgent.

4. Please notify the medical assistant of any medication changes, even if prescribed by another provider. It is imperative that your electronic health record with us be as current and accurate as possible, so that we can appropriately care for you.

5. Payments are due at the time of visit. This includes coinsurances, estimated, and confirmed deductibles, and self-pay payments. For your convenience, we accept cash, check, American Express, Discover, MasterCard, and Visa.

6. Please provide the front office with updated insurance, address, phone, and other changes at the first appointment after the change. Failure to provide this information may result in unnecessary patient liability for payment.

RESCHEDULE, CANCELLATION, AND NO-SHOW POLICY

We understand that situations arise in which you must cancel or reschedule your appointment. It is requested that if you must cancel or reschedule your appointment you provide at least 48- hour notice. This will allow for another patient who is waiting for an appointment to be scheduled in that appointment slot. Office appointments and procedures which are cancelled or rescheduled with less than 48 hours notification may be subject to a $35.00 fee. This fee will be required to be paid prior to another appointment being scheduled for the patient.

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Patients who do not show up for their appointment or procedure and do not call to cancel or reschedule their appointment will be considered a NO SHOW. Patients who no show three (3) or more times in a 12-month period, may be dismissed from the practice and denied any future appointments. Patients that no show will also be subject to the $35.00 cancellation fee.

Our practice firmly believes that good provider/patient relationship is based upon understanding and good communication. Questions about our cancellation, reschedule, and no-show fees can be directed to our Billing Department.

I have read and understand Elite Dermatology's office policies as outlined in this document and agree that they are an established part of this practice. By signing this agreement, you are attesting that you have been informed and understand our policies. You are also attesting that you understand that charges related to late rescheduled, no shows, or cancelled appointments will be charged or billed directly to you, not your insurance company.

_____ _____

Signature of patient or personal representative Signature of Witness