PATIENT DATA

CLINICAL DATA (HISTORY OF PRESENT ILLNESS)

DATE: _____

PATIENT'S NAME: _____ DOB: _____
SOCIAL SECURITY #: _____

PATIENT'S SKIN COMPLAINT: _____
_____
LOCATION OF SKIN PROBLEM:_____
_____
DURATION OF SKIN PROBLEM:_____
DOES ANYTHING MAKE IT WORSE/BETTER? _____
_____
CHRONICITY: ____NEW ____INTERMITTENT ____PERSISTENT OTHER_____
OTHER SYMPTOMS:____ITCH ____BURN ____ HURTS____ FEVER____ OTHER
_____
_____
TREATMENTS USED SO FAR AND EFFECT ON SKIN PROBLEM
_____
_____
_____
_____
PRIOR EVALUATIONS OF SKIN PROBLEM (BY WHO, THEIR DIAGNOSIS & TREATMENT)
_____
_____
_____
_____
LABS & BIOPSIES PENDING
_____
_____
_____
_____

PAST MEDICAL HISTORY

LIST ALL CURRENT MEDICATIONS WITH START DATES:
_____
_____
_____
_____

VACCINATION HISTORY:
_____
_____
_____
_____

MEDICATION ALLERGY HISTORY:
_____
_____
_____
_____

FOOD, RESPIRATORY, OR SKIN ALLERGY HISTORY:

HISTORY OF SKIN PROBLEMS:

HISTORY OF ENDOCRINE PROBLEMS:

HISTORY OF COLLAGEN VASCULAR DISEASE:

HISTORY OF PULMONARY PROBLEMS:

HISTORY OF CARDIOVASCULAR PROBLEMS:

HISTORY OF GASTROINTESTINAL PROBLEMS:

HISTORY OF RENAL PROBLEMS:

HISTORY OF NEUROLOGICAL PROBLEMS:

HISTORY OF MUSCULOSKELETAL PROBLEMS:

_____
_____
_____
_____

HISTORY OF PSYCHIATRIC PROBLEMS:

_____
_____
_____
_____

HISTORY OF INFECTIOUS DISEASES:

_____
_____
_____
_____

HISTORY OF CANCER:

_____
_____
_____
_____

MENSTRUAL & PREGNANCY HISTORY:

_____
_____
_____
_____

SURGICAL HISTORY:

_____
_____
_____
_____

Insurance Information Form

ACCOUNT No._____ DATE:_____

NAME OF INSURANCE:_____

Circle One: PPO

HMO (If HMO you will need Insurance Referral from PCP)

OTHER

NAME OF SUBSCRIBER:_____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____

Circle One: PPO

HMO (If HMO you will need insurance Referral from PCP)

OTHER

NAME OF SUBSCRIBER: _____

PATIENT NAME: _____

MEMBER ID# _____SECOND ID#_____

GROUP # _____SECOND GROUP # _____

STUDENT: YES NO PART TIME FULL TIME SCHOOL_____

ELIGIBLE START DATE: _____END DATE: _____

DEDUCTIBLE (if any): $_____.00 DEDUCTIBLE REMAINING: $_____.00

SPECIALIST COPAY: $_____.00

ATTENTION ALL PATIENTS:
ALONG WITH YOUR COMPLETED HISTORY FORM AND INSURANCE FORM, PLEASE BRING PROOF OF INSURANCE CARDS WITH YOU ON YOUR APPOINTED DAY. IF YOU ARE IN AN HMO PLAN YOU WILL NEED TO BRING YOUR PCP REFERRAL FORM AS WELL. DON'T FORGET TO BRING A LIST OF ALL CURRENT MEDICATIONS! THANK YOU.

PHARMACY & LAB CHOICES: IN THE EVENT YOU WILL REQUIRE A PRESCRIPTION(S) OR LAB STUDIES, IF APPLICABLE, PLEASE PROVIDE US WITH YOUR (INSURANCE'S) PHARMACY & LAB OF CHOICE.

PHARMACY: _____ ADDRESS: _____

LAB: _____ ADDRESS: _____

EXHIBIT P4

HIPPA FORM

Hector L. Franco, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Hector L. Franco M.D. I hereby acknowledge receipt of Hector L. Franco M.D's Notice of Privacy Practices.

Name (please print):_____

Signature: _____

Date: _____

Or

I am a parent or legal guardian of _____(patient name). I hereby acknowledge receipt of Hector L. Franco M.D.'s Notice of Privacy Practices with respect to the patient.

Name (please print): _____

Relationship to patient: [ ] Parent [ ] Legal guardian

_____ _____
Signature Date

A PHOTOCOPY OF THIS FORM (SIGNED) IS AS VALID AS THE ORIGINAL

EXHIBIT P6

Patient Authorization for Practice to Release Protected Health Information (PHI)

Our Notice of Privacy Practices provides information about how this office may use and disclose your Protected Health Information or PHI. On occasion you the patient or Dr. Franco's office may want to use your PHI for reasons other than those that involve treatment, payment or health care operations. This form is designed to allow you to specify which persons or entities Dr. Franco's office can share your PHI with and under what special circumstances. Our office provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Please indicate with your initials which **part of your PHI** is to be used or disclosed, include dates if appropriate. If applicable, on the lines below, specify purpose of use.

_____Doctor's notes _____Patient photos

_____Lab & Biopsy results _____Demographics

_____Billing & Insurance Info _____Other_____

Purpose: _____

Please write the **names of the individuals or entities** that may receive and use the disclosed information & their relationship to you. ( )spouse ( )son/daughter ( )friend ( )other_____

_____

Expiration date of this authorization: _____

The above mentioned Protected Health Information (PHI) may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize our office to use and disclose your PHI for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However such a revocation shall not affect any disclosure we have already made in reliance on your prior authorization. Submit your revocation to the office manager of our office.

Signature: _____ Date: _____

This authorization was signed by: _____
Printed name-Patient or Representative

Witness: _____ _____
Name Date

Relationship to patient (if other than patient): _____

Cosmetic Interest Questionnaire
(Optional)

___ SKIN CARE ADVICE

___ SKIN CARE PRODUCTS

___ SUN PROTECTION

___ BOTOX FOR WRINKLES

___ BOTOX FOR SWEATING PROBLEMS

___ GLYCOLIC (SUPERFICIAL) CHEM PEEL

___ TCA (MEDIUM) CHEM PEELS

___ TREATMENT FOR SPIDER VEINS

___ EXCESSIVE HAIR

___ SKIN TAGS

___ LASER HAIR REMOVAL

___ PRODUCTS/TREATMENTS ANTI-AGING

___ SUN SPOTS/AGE SPOTS

___ COSMETICS

___ DRY SKIN/MOISTURIZERS

___ RESTYLANE/DERMAL FILLERS

___ ENLARGED OIL GLANDS

Please note: If we find that your questions will require extra time to address we may need to schedule you for an additional or follow up visit so we can address all your interests and concerns properly.

May we mail you information regarding our products or services? YES___ NO___ INITIALS____