701 Metairie Road
Suite 2A-205
Old Metairie Village
Metairie, LA 70005

OLD METAIRIE DERMATOLOGY
PATRICIA K. FARRIS, M.D., F.A.A.D.
MAMINA TUREGANO, M.D., F.A.A.D.

Dermatology & Dermatologic Surgery

Ph 504/836-2050
Fax 504/836-9795

FOR OFFICE USE ONLY

Referring Doctor _____ Account# _____

PATIENT INFORMATION

Please respond to each item - ***Please Print*** Date _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
NUMBER STREET CITY STATE ZIP

Sex _____ Date of Birth ____/____/____ SS# _____

Home Phone (____) _____ Cell Phone _____ email address _____

Patient's Employer _____ Position _____ Bus Phone _____

Marital Status _____ Spouse _____ Spouse's DOB _____ Spouse's SS# _____

Spouse's Employment _____ Position _____ Bus Phone _____

IF PATIENT IS A MINOR - Guarantor/Billing Information:

Name _____ Relationship to Patient _____ SS# _____ DOB ____/____/____

Address _____
NUMBER STREET CITY STATE ZIP

Name of Employer _____ Position _____ Bus. Phone _____

NOTIFY IN CASE OF EMERGENCY (other than spouse) Name: _____

Relationship _____ Home Phone _____ Bus. Phone _____

Address _____
NUMBER STREET CITY STATE ZIP

FRONT COPY OF CARD
(For Office Use Only)

BACK COPY OF CARD
(For Office Use Only)

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. Signed: X Date:	I authorize payment of medical benefits to the physician or supplier for services described. Signed: X
I authorize this organization to leave a message on my answer machine. Yes ☐ No ☐ I authorize this organization to discuss my condition / account with the person/s listed. Yes ☐ No ☐ If yes, list below. Signed: X Date:	

MEDICAL HISTORY

Name X _____ Date _____

Reason for Visit _____

Do you have or have you recently had any of the following problems?

Y N Fever	Y N Swollen glands	Y N Discoloration of hands & feet
Y N Headaches/migraine	Y N Asthma	Y N Diabetes
Y N Sore throat	Y N Chest pain	Y N Burning on urination
Y N Sinus problems	Y N Runny nose/hay fever	Y N Varicose veins
Y N Irregular heart beat	Y N Diarrhea	Y N Hives
Y N Shortness of breath	Y N Discoloration of stool	Y N Changing or bleeding moles
Y N Seasonal allergies	Y N Hepatitis	Y N Last Tet. Shot
Y N Nausea/vomiting	Y N Frequency of urination	Y N Alcohol use
Y N Weight loss/gain	Y N Swelling of legs	Y N Cigarettes
Y N Red irritated eyes	Y N Skin rashes	Y N Drug use

List all significant medical illnesses or injury with year of occurrence

_____

_____

_____

Hospitalizations & year of occurrence

1. _____
2. _____
3. _____

Have you ever had a skin cancer or malignant melanoma? Yes / No

If yes, please explain _____

_____

_____

Medications _____

1. _____
2. _____
3. _____

Drug Allergies:

_____

_____

Family History

	Age	Health Status	Deceased (give cause)
Mother			
Father			
Siblings			

Patricia K. Farris, M.D., F.A.A.D.
Mamina Turegano, M.D., F.A.A.D.

NOTICE OF PRIVACY PRACTICES

CONSENT FOR PURPOSES OF TREATMENT.PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by P.K. Farris, M.D. II, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of P.K. Farris, M.D. II, Inc. I understand that diagnosis or treatment of me by Patricia K. Farris, M.D. or Mamina Turegano, M.D. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment payment, payment or healthcare operations of the practice. P.K. Farris, M.D. II, Inc. is not required to agree to the restrictions that I may request. However, if P.K. Farris, M.D. II, Inc. agrees to restrictions I request the restriction is binding on P.K. Farris, M.D. II, Inc., Patricia K. Farris, M.D. and Mamina Turegano, M.D.

I have the right to revoke this consent in writing at anytime except to the extent P.K. Farris, M.D. II, Inc. Patricia K. Farris, M.D. or Mamina Turegano, M.D. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review P.K. Farris, M.D. II, Inc.'s Notice of Privacy Practices prior to signing this document. The P.K. Farris, M.D. II, Inc.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of P.K. Farris, M.D. II, Inc. The Notice of Privacy Practices for P.K. Farris, M.D. II, Inc. is also provided in the reception area. The Notice of Privacy Practices also describes my rights and the P.K. Farris, M.D. II, Inc. duties with respect to my protected health information.

P.K. Farris, M.D. II, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X _____ _____

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

X _____ _____

Signature of Patient or Personal Representative

Date

Name _____

E-mail Address _____@_____

Date _____

Cosmetic Interest Survey

Our practice offers comprehensive dermatology treatment including medical, surgical and cosmetic dermatology. Our physicians are nationally known experts in the use of non-invasive procedures to rejuvenate the skin like laser resurfacing, IPL, dermal fillers and Botox®. Our expertise earned us recognition by the readers of Gambit who voted Dr. Farris the best dermatologist in New Orleans, and our practice among the top three best practices providing cosmetic procedures.

This survey is intended to determine if you might have any cosmetic concerns or questions that we may be able to assist you with.

1. Which of the following cosmetic issues are of concern to you? (circle all that apply)
    a. General skin care or skin care regimen
    b. Facial pigmentation or freckling
    c. Sun damaged skin
    d. Brown spots
    e. Wrinkles and fine lines
    f. Smile lines
    g. Frown lines
    h. Thinning of the lips
    i. Dark circles
    j. Under eye puffiness
    k. Unwanted facial hair
    l. Unwanted hair elsewhere
    m. Chest and neck discoloration
    n. Leg veins
    o. Hair thinning or hair loss

2. Have you had any Cosmetic procedure, laser treatment or cosmetic surgery in the past? If yes, please list Yes / No
    a. Yes _____

3. Would you be interested in receiving information about new cosmetic treatments or promotions via email? Yes / No