5701 Ambassador Caffrey
Youngsville, LA 70592
(337) 456-3323 Office
(337) 456-4638 Fax
drjennifermyers.com

NEW PATIENT REGISTRATION

Welcome to Myers Dermatology! We appreciate the trust you have placed in us and look forward to providing you with the highest quality patient care. This packet includes our new patient paperwork for your first visit with Dr. Myers. You may either fax it back to us at 337-456-4638 or bring it with you to our office.

Please bring the following items with you to your first appointment:

- Completed forms contained in this packet
- A copy of the patient/patient's guardian's insurance card(s) and driver's license will be made at time of check in.
- List of all current over-the-counter and prescription medicines
- Co-payment or deductible is due to at the time of service. We do not bill patients. We accept cash, check, or Visa/Mastercard.
- Parent or guardian must accompany all patients under 18 years old if procedure is to be performed
- Myers Dermatology has the right to charge $1.00 per page for printing, completing, and/or copying any patient documentation. Staff will also need a 48 hours notice prior to information being needed by patient.

OUR LOCATION

We are located on the Ambassador Caffery Extension, south of Our Lady of Lourdes Hospital at the intersection of Ambassador and Chemin Metarie.

5701Ambassador Caffrey
Youngsville, LA 70592

PATIENT'S PERSONAL INFORMATION

Name _____ _____ _____
First Initial Last

Date of Birth ____/____ /____ Sex: ❒ M ❒ F SSN: ____-____-____ Race _____

Marital status: ❒ Single ❒ Married ❒ Divorced/separated ❒ Widowed

Home Phone (____) _____ Work (____) _____ Cel l (____) _____

Preferred contact phone ❒ Cell ❒ Home ❒ Work

Address: _____ _____ _____ _____ _____
Street Apt City State Zip

E-Mail Address: _____

PERSON RESPONSIBLE FOR BILL (Complete only if different from patient)

Name _____ Relationship _____

Date of Birth ____/____ /____ Phone (____)_____

Address: _____ _____ _____ _____ _____
Street Apt City State Zip

PRIMARY MEDICAL INSURANCE

Insurance Co. _____ Employer _____

Policyholder: Name _____Date of birth _____ SSN _____

Relationship: ❒ Self ❒ Spouse ❒ Child ❒ Other

SECONDARY MEDICAL INSURANCE

Insurance Co. _____ Employer _____

Policyholder: Name _____Date of birth _____ SSN _____

Relationship: ❒ Self ❒ Spouse ❒ Child ❒ Other

OTHER

Preferred Pharmacy _____ Location _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about Dr. Myers? _____

Primary Care Physician:_____

Pediatrican:_____

Personal Medical History

MEDICATION ALLERGIES

_____ _____ _____

CURRENT MEDICATIONS

_____ _____ _____
_____ _____ _____
_____ _____ _____

MEDICAL HISTORY (PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY)

❒Asthma
❒Allergies
❒Diabetes
❒Elevated Cholesterol
❒Hyperthyroidism
❒Hormonal Imbalance
❒Heart Disease
❒Hypothyroidism
❒Anxiety
❒Depression
❒Insomnia
❒GERD
❒Migraines
❒Lupus
❒Rheumetoid Arthritis
❒Fibromyalgia
❒COPD
❒ADD/ADHD
❒Kidney Disease
❒Anemia

Other:_____

PAST SURGERIES / HOSPITALIZATIONS

_____ _____ _____

New rash	❒ Yes	❒ No
Changing mole	❒ Yes	❒ No
Fever or chills	❒ Yes	❒ No
Rapid weight change	❒ Yes	❒ No
Excessive anxiety or sadness	❒ Yes	❒ No
Blurred or changing vision	❒ Yes	❒ No
Joint pain or swelling	❒ Yes	❒ No
Hay fever or seasonal allergies	❒ Yes	❒ No
Chest pain or shortness of breath	❒ Yes	❒ No
Leg swelling	❒ Yes	❒ No
Change in bowel habits	❒ Yes	❒ No
Enlarged glands under skin	❒ Yes	❒ No
Trouble urinating	❒ Yes	❒ No
Pregnant or breastfeeding	❒ Yes	❒ No
Do you smoke	❒ Yes	❒ No
Are you married	❒ Yes	❒ No
History of sunburns	❒ Yes	❒ No
Did your parents have skin cancer?	❒ Yes	❒ No
Family history of psoriasis or eczema?	❒ Yes	❒ No

5701 Ambassador Caffrey
Youngsville, LA 70592
(337) 456-3323 Office
(337) 456-4638 Fax
drjennifermyers.com

ACKNOWLEDGEMENT OF OFFICE POLICIES

INSURANCE FILING AUTHORIZATION

I certify that the information contained in my registration and health history forms is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Myers Dermatology. I also authorize Myers Dermatology to release any information to my insurance company required to process my claims. I agree that a photocopy or scan of this agreement shall be as valid as the original.

NOTICE OF PRIVACY PRACTICES

I authorize the release of any medical information necessary to evaluate or treat my condition or to process insurance claims on my behalf. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

PAYMENT POLICIES

Payment is due at time of service. We do not bill patients. This amount includes any co-pay or outstanding insurance deductible. I understand that I am financially responsible for all services rendered on my behalf, whether or not they are covered by my insurance, on the day of service.

CANCELLATION POLICY

We reserve Dr. Myers time especially for you, therefore, it is the patient's responsibility to call and cancel at least 24 hours prior to the scheduled appointment during our normal business hours, if needed. Myers Dermatology reserves the right to charge a $35 no-show fee. This policy is in place to provide your appointment to another patient who is waiting to be seen. Myers Dermatology reserves the right to reschedule appointments that are 15 min late.

PREFERRED PHARMACY: We send all our prescriptions electronically to your pharmacy.

Pharmacy _____ Location _____

REASONS FOR YOUR VISIT TODAY:

_____

_____

_____

Please sign below indicating that you understand and agree to our office policies.

_____ _____

Patient name / (Guardian, if applicable) Date

Designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPPA) allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Myers Dermatology LLC realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, Myers Dermatology will not release information to any family member or friend or legal representative.

Designation Statement

I, _____, designate the following person to be able to speak to a physician at Myers Dermatology LLC, or other staff member, should it be necessary, on my behalf. I hereby give permission to Myers Dermatology LLC through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release Myers Dermatology LLC its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person:_____

Relationship: _____Phone Number: _____(home/work)

Patient's Name:_____

Patient's Signature:_____

Date: _____Witness:_____

I decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: _____

Date: _____Witness: _____

Skin Health Questionnaire

Name _____ **Age** _____ **Sex M / F**

Occupation _____ **Phone Number** _____

Allergies _____ Pregnant, or trying to get pregnant? Y / N

What type of makeup, if any, do you use? _____

What cleanser do you use? _____ Moisturizer? _____

What other skin care products are you currently using? _____

_____

Are you using acne medication? Y / N If yes, what kind?_____

Do you get cold sores? Y / N

Do you use tanning beds/sunbathe? Y / N

Do you wear a daily sunscreen? Y / N If so, what kind? _____

Skin Type: Normal Dry Oily Acne-prone

When you get sun exposure, do you burn? (circle one)

Always Usually Sometimes Rarely Never

Rate your current stress level 0 (not stressed) – 10 (extremely stressed): _____

What are the main skin concerns do you have?

□ Fine lines/wrinkles

□ Oily skin

□ Acne

□ Facial redness / veins

□ Hair removal

□ Brown spots/Sun damage

□ Acne scarring

□ Pore Size

□ Anti-aging skin care

□ Lip enhancement

□ Stretch marks

Please provide your e-mail address if you would like to receive e-mails about promotions, specials, and events: _____