OXFORD DERMATOLOGY
2204 Jefferson Davis Drive, Oxford, MS 38655
phone: (662) 236-6850 fax (662) 236-5010

New/Update

PATIENT INFORMATION (please print)

Patient Name _____ MI ____ Last _____ Goes by _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____ e-mail address _____

Home Phone ( ) _____ Cell Phone ( ) _____

Social Security Number _____ Marital Status _____ Spouse _____

Employer Name & Address _____City/State _____

Employer Phone _____ Department in Which Employed _____

Spouse Employer _____ Spouse Employer Address & Phone _____

IF CHILD/STUDENT, GUARDIAN IS RESPONSIBLE FOR BILL

Father Name _____ Address _____ Phone _____

Mother Name _____ Address _____ Phone _____

Fathers Employer Name & Address _____ Empl. Phone _____

Mothers Employer Name & Address _____Empl. Phone _____

INSURANCE INFORMATION

Primary Ins. Company _____ Insured Name _____

Insured Date of Birth _____ Insured Employer _____ Relationship: Self / Spouse / Other

Identification Number _____ Gr. # _____

SECONDARY INSURANCE INFORMATION

Secondary Ins. Company _____ Insured Name _____

Insured Date of Birth _____ Insured Employer _____ Relationship: Self / Spouse / Other

Identification Number _____ Gr. # _____

ACCIDENT INFORMATION

Were you on the job? Yes / No Date of accident or injury? _____

REFERRING PHYSICIAN _____

FAMILY PHYSICIAN _____ City _____ Phone ( ) _____

EMERGENCY CONTACT _____ Phone ( ) _____ Relation _____

DISCLOSURE

All professional services rendered are charged to the patient. In Medicare/Other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other insurance company as the full charge, and the patient is responsible for the deductible, coinsurance, and noncovered services. **If payment is not made by your Insurance Company within 90 days, the balance is your responsibility.** However, I UNDERSTAND that I am responsible for all fees regardless of whether or not paid by said insurance.

SIGNATURE ON FILE

I authorize: the use of this form on all my insurance submissions, release of information to all my Insurance Companies, my doctor to act as my agent in helping me obtain payment from my Insurance Companies, payment direct to my doctor, a copy of this authorization to be used in place of the original.

Signature of Responsible Party _____ Date _____

MEDICAL HISTORY

Date:_____

Name: _____ DOB:_____ Account #:_____

PLEASE DESCRIBE THE NATURE OF YOUR PROBLEM(S). INCLUDE DURATION AND SYMPTOMS.

LIST ALL PAST MEDICAL PROBLEMS, SURGERIES, AND HOSPITALIZATIONS.

LIST ALL DRUG ALLERGIES OR REACTIONS.

HAVE YOU EVER HAD A PROBLEM WITH:

☐ CODEINE ☐ PENICILLIN ☐ KEFLEX ☐ SULFA ☐ BACTRIM ☐ TETRACYCLINE

☐ ASPIRIN ☐ ERYTHROMYCIN ☐ TETANUS ☐ HORMONES ☐ ORAL CONTRACEPTIVES ☐ LAXATIVES

ARE YOU ALLERGIC TO ANY OF THE ITEMS LISTED BELOW? CIRCLE ALL THAT APPLY.

ANIMALS PLANTS METAL POLLEN FISH SHELLFISH DAIRY PRODUCTS SOAP

EXPLAIN:

CIRCLE ALL CONDITIONS THAT AFFECT YOU:

ASTHMA BRONCHITIS SINUSITUS EYE ALLERGIES NOSE ALLERGIES RASHES

IF YOU USE ALCOHOL OR TOBACCO, LIST AMOUNT AND FREQUENCY.

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING OR THAT YOU HAVE TAKEN IN THE LAST 2 WEEKS. THIS SHOULD INCLUDE VITAMINS, LAXATIVES, CONTRACEPTIVES, TYLENOL, ETC. **IF YOU NEED MORE ROOM, PLEASE ATTACH A SEPARATE SHEET.**

MEDICATION NAME	DOSE	HOW OFTEN	MEDICATION NAME	DOSE	HOW OFTEN

WOMEN

ARE YOU PREGNANT? YES NO **DATE OF LAST MENSTRUAL PERIOD**_____ **ARE YOUR PERIODS REGULAR?** _____

IF MENOPAUSE, WHEN? _____ **# OF PREGNANCIES** _____ **# OF MISCARRIAGES** _____

PLEASE LIST ALL DISEASES THAT RUN IN YOUR FAMILY, INCLUDING DIABETES, HIGH BLOOD PRESSURE, CANCER, ALLERGIES, ETC.

_____ SIGNATURE

_____ DATE

Acceptance of Disclosure Statement:

I understand that a copy of the Notice of Privacy Practices for Protected Health Information (PHI) for Oxford Dermatology, Philip R. Loria, JR., M.D, is posted for my review and a copy will be given to me upon my request.

In addition to the use and disclosure of your medical information stated in the Notice of Privacy Practices for Protected Health information, I hereby give permission for the following individuals to receive the requested information, the individual must identify themselves by name and provide my date of birth upon request by our staff.

Immediate Family Members (Limit 3)	Relationship	Phone #

None _____

_____ _____

Patient Name Account Number

_____ _____

Signature of Patient or Representative Date

To revoke or change the above authorizations, please contact us:

Oxford Dermatology

Philip R. Loria, Jr., M.D.
2204 Jefferson Davis Drive
Oxford, MS 38655
Office: (662) 236-6850 Fax: (662) 236-5010

Notice of Privacy Practices

Date:_____

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of and/or access to the "Notice of Privacy Practices" for Oxford Dermatology. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. A full copy of this document is available at our office or online from our secure patient portal.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our patient portal or by contacting our office at (662) 236-6850.

Link to the Oxford Dermatology Secure Patient Portal:
http://oxforddermatology.portalforpatients.com/portal

If you have any questions about our "Notice of Privacy Practices," please contact:

Oxford Dermatology
Attn: Privacy Officer
2204 Jefferson Davis Drive
Oxford, MS 38655

I acknowledge receipt of the "Notice of Privacy Practices" of Oxford Dermatology.

Signature: _____

Date: _____

Patient Name:_____

Acct #: _____ D.O.B. _____

The form expires on revocation by the patient or 10 years after the patient was last seen here.

OXFORD DERMATOLOGY

Philip R. Loria, Jr., M.D.

STATEMENT OF FINANCIAL RESPONSIBILITY

NO SHOW/CANCELLATION POLICY

In order to provide the best care in a timely manner we ask that you give 24 hour notice if you will not be able to keep your scheduled appointment/procedure. Those not giving adequate notice will be assessed a $50.00 cancellation fee. By signing you acknowledge Oxford Dermatology's cancellation policy.

I understand that I am financially responsible for payment for all services rendered. Although this practice may bill and/or accept payments from my insurance carrier, I understand that I am responsible for all charges for services rendered regardless of any insurance coverage.

I agree to pay all deductibles and copayments at the time of service.

In the event that I fail to pay my balance, and my account is turned over for collection, I agree to pay all collection costs incurred, including, but not limited to, collection fees, reasonable attorney fees and court costs.

INSURANCE CERTIFICATION AND AGREEMENT

I provide insurance to this practice. I understand I am solely responsible for the accuracy of such information. In the event I provide incorrect information, partially correct information, or fail to notify the practice of insurance changes on, or before, the date of service, then I agree that I assume sole responsibility for payment for services even though they may have been covered had I provided correct and timely insurance information. This insurance certification and agreement shall supersede any agreements the practice has with any insurance carriers.

_____

Print patient's name

_____ _____

Signature of patient or responsible party Date