

Dermatology & Laser Center of San Antonio

PATIENT INFORMATION

Please fill out **COMPLETELY**.

Patient's Full Name: _____
(First) (Middle) Last

Address: _____

(City)

(State)

(Zip)

Date of Birth: _____ Social Security # _____

Sex: Female Male

Marital Status: M S D W

Race: American Indian/Alaska Native Asian Black/African American More than one race
 Native Hawaiian Pacific Islander White Refused to Report

Ethnicity: Hispanic/Latino Not Hispanic/Not Latino Language: _____

Home Phone # _____ Mobile Phone # _____

Employer: _____ Work Phone # _____

Email Address: _____

Preferred Method of Communication: Postal Mail Phone Email

INSURANCE INFORMATION

Primary Insurance Plan Name: _____

Name of Insured (if other than patient): _____

Date of birth: _____ Address: _____

Secondary Insurance Plan Name: _____

Name of Insured (if other than patient): _____

Date of birth: _____ Address: _____

How did you hear about us?

My insurance company The Yellow Pages My Doctor (name) _____

Newspaper Internet/Website

Saw location / Walk-In A friend / family member _____

YES, The practice may discuss my confidential medical information, treatment, appointments, prescriptions, pathology and/or lab results with the following person(s) including disclosure by telephone, fax or email. **PLEASE LIST NAMES BELOW.**

Name	Relationship	Phone#

PHARMACY, LOCATION & PHONE #: _____

Past Medical History (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyper/Hypothyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> BPH | <input type="checkbox"/> GERD | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Cancer (other than skin) _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> None |

Other _____

Surgical History (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Removed (Right, Left |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Transplant (Kidney, Liver, Heart, Other) |
| <input type="checkbox"/> Breast: Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries removed (Endometriosis, Cyst, Ovarian Cancer) |
| <input type="checkbox"/> Breast: Lumpectomy (Right, Left, Bilateral) | <input type="checkbox"/> Prostate removed: Prostate cancer |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Prostate: TURP |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Basal Cell Cancer surgery |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Squamous Cell Carcinoma Surgery |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Melanoma surgery |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Skin Biopsy |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Spleen removed |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Heart: PTCA (proc. for blocked coronary arteries) | <input type="checkbox"/> None |
| <input type="checkbox"/> Heart: Mechanical/Biological Valve Replacement | |
| <input type="checkbox"/> Joint Replacement within last 2 years | |

Other _____

Do you have any of the following skin conditions (please check all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Flaking or itchy scalp | <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> None |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Squamous cell skin cancer | | |

Other _____

Do you have a **family** history of *Skin* Cancer? yes no (If yes, please check all that apply)

- Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

Which relative(s)? _____

Do you wear sunscreen? Yes No If yes, what SPF _____

Do you tan in a tanning salon? Yes No

Social History (please check all that apply)

Alcohol Use:

- no alcohol use
 Less than 1 drink per day
 1-2 drinks per day
 3+ drinks per day

Tobacco Use:

- Currently smokes daily
 Currently smokes – not daily
 Has never smoked
 Has smoked in the past

Medications (please list all current medications, including vitamins/supplements/herbal remedies and non-prescriptions ie aspirin, ibuprofen)

Are you allergic to any Medications? YES NO

List Allergies to Medications and type of allergic reaction(example: hives, difficulty breathing, swelling, etc)
NONE

Review of Systems (Please check all that apply regarding your overall health and add any other important information)

- | | | |
|--|--|--|
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Unintentional Weight Loss | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Problems with scarring (keloid) | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bloody Urine | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Joint Aches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Muscle Weakness | |

Alerts

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Allergy to adhesive | <input type="checkbox"/> Artificial joints within past 2 years | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to lidocaine | <input type="checkbox"/> Blood thinners | |
| <input type="checkbox"/> Allergy to topical antibiotic ointments | <input type="checkbox"/> Defibrillator | |
| <input type="checkbox"/> Rapid heartbeat with epinephrine | <input type="checkbox"/> MRSA | |
| <input type="checkbox"/> Artificial heart valve | | |
| <input type="checkbox"/> Pregnant or planning pregnancy | | |

Do you have any other medical history that you would like us to be aware of?

Name _____ Date _____

CONSENT FOR TREATMENT: I hereby consent to treatment and/or services, by providers at the Dermatology & Laser Center of San Antonio to include examination, treatment, prescribing medication and skin preparations. If the patient is a minor and presents to be evaluated and/or treated by a provider at this practice without me or an accompanying parent/legal guardian (**after the initial visit**) I hereby give my permission to evaluate and treat the minor patient.

RELEASE OF INFORMATION: I hereby authorize the release of any & all medical information to my insurance carrier(s) or their representative, for purposes necessary in the adjudication or processing of any & all insurance claim(s) filed on my behalf & for which I am financially responsible. I also authorize the release of any or all medical information to my primary care or referring physician, to consultants if needed, and as necessary to process prescriptions.

ASSIGNMENT OF BENEFITS: I further authorize all insurance benefits be paid to the provider rendering services on behalf of the Dermatology & Laser Center of San Antonio. I understand that payment for professional services, including co-payments and deductibles and fees for cosmetic services are due at time services are rendered. I acknowledge that if my managed care plan declines to cover a service for any reason, it becomes the sole obligation of the patient, parent or guardian to pay in full.

PRIVACY PRACTICES (HIPAA) AND OFFICE POLICIES: I acknowledge that I have received a copy of the Dermatology & Laser Center's **Notice of Privacy Practices** and **Office Policies**. These documents are posted on our website and are always available at the Front Desk.

PATHOLOGY & LAB FEES: Anytime a growth is removed from the skin, the tissue will be automatically sent for pathology. Our office uses an outside pathologist and/or lab for these services. You will receive a separate bill from the pathologist or lab for any services they render.

EMAIL POLICY: The Dermatology & Laser Center of San Antonio subscribes itself to the principles of email privacy. Any information submitted will be used only for requested information and internal purposes and will not be sold or revealed to any third parties.

I have reviewed, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient or Authorized Signature

(Relationship to Patient)

Date

Acknowledgement of Privacy Practices (HIPAA)

By signing this form, I am confirming that I have been informed of my rights to privacy regarding my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Process insurance claims, insurance applications, and prescriptions.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I have been given the right to review and receive a copy of such Notice. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used. I also understand that you are not required to agree to my requested restriction(s), but if you do agree then you are bound to abide by such restriction(s). If I do not sign this consent, Dermatology & Laser Center of San Antonio may decline to provide treatment to me.

I have read and consent to the above information.

Patient or Authorized Signature

(Relationship to Patient)

Date