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#
Name	Relationship	Phone #

PHARMACY, LOCATION & PHONE #:_____

_____

Past Medical History (please check all that apply)

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

☐ Other _____

Surgical History (please check all that apply)

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

☐ Other_____

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

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or itchy scalp
- ☐ Squamous cell skin cancer
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ None

☐ 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:

- ☐ **n**o 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)

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

Alerts

☐Allergy to adhesive
☐Allergy to lidocaine
☐Allergy to topical antibiotic ointments
☐Rapid heartbeat with epinephrine
☐Artificial heart valve
☐Pregnant or planning pregnancy
☐Artificial joints within past 2 years
☐Blood thinners
☐ Defibrillator
☐MRSA
☐Pacemaker

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**