Joe M. Lehman, M.D.
Michael Lehman, M.D.

David Long, M.D.
Bryan D. Harris, M.D.

Lehman Dermatology Clinic Professional Association

PATIENT INFORMATION

❑New Patient ❑Name Change ❑Address Change ❑Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date _____/_____/_____

Name _____
Last First M.I.

Date of Birth _____/_____/_____ Sex: ❑Male ❑Female SS# _____-____-_____

CONTACT INFORMATION:

Mailing Address _____
City State Zip

Home Phone (____)_____ Cell Phone (____)_____

E-mail Address _____

Employer _____ Work Phone (____)_____

If patient is child, check relationship: ❑Mother ❑Father ❑Other: _____

Next of Kin _____ Phone (____)_____ Relationship _____
(not living at same address)

PARENT, SPOUSE, OR RESPONSIBLE PARTY: SS# _____-____-_____
(if different from patient)

Name _____ Date of Birth:_____/_____/_____
Last First M.I.

Address _____
City State Zip

Home Phone (____)_____Cell Phone (____)_____

E-mail Address _____Employer_____

INSURANCE COVERAGE—PRIMARY: SS# of Policy Holder _____-____-_____

Insurance Co Name _____

Name of Policy Holder (Insured) _____

Policy Holder (Insured) Date of Birth _____/_____/_____ Employer_____

INSURANCE COVERAGE—SECONDARY: SS# of Policy Holder _____-____-_____

Insurance Co Name _____

Name of Policy Holder (Insured) _____

Policy Holder (Insured) Date of Birth _____/_____/_____ Employer_____

Please present insurance card(s) and photo ID to the receptionist so copies may be made.

Joe M. Lehman, M.D.
Michael Lehman, M.D.

David Long, M.D.
Bryan D. Harris, M.D.

Lehman Dermatology Clinic Professional Association

MEDICAL HISTORY

Patient _____ **Patient's Date of Birth** ____/____/____

Reason for today's visit _____ Referring Doctor _____

Are you allergic to any medications? ❑Yes ❑No If yes, list below:

_____

Have you ever had dental anesthesia (Novocaine)? ❑Yes ❑No Any bad reactions? ❑Yes ❑No
List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Do you have now, or have you ever had diseases or conditions of: (Please check yes or no)

Lungs:	**Yes**	**No**
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	**Yes**	**No**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of Vein	❑	❑
Blood Clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**Yes**	**No**
Diabetes	❑	❑
Excessive Thirst/Hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/Burning	❑	❑
Gastrointestinal		
Stomach Absorptive Disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited Motion	❑	❑
Artificial Joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions _____

List surgical procedures you have had in the last 6 months _____

Skin:
Have you ever had skin cancer? ❑Yes ❑No
Has anyone in you family had skin cancer? ❑Yes ❑No
Do you have a history of any specific skin diseases? ❑Yes ❑No If yes, _____
Do you have problems with healing? ❑Yes ❑No
Do you develop keloids (scars) after surgery? ❑Yes ❑No
Do you bleed easily? ❑Yes ❑No
Do you develop skin rashes in reaction to ❑Medications ❑Food ❑Environment ❑Bandages ❑Topical Neosporin ❑Other _____

Social History:
Do you drink alcohol? ❑Yes ❑No If yes, _____ drinks per day
Do you use IV drugs? ❑Yes ❑No If yes, what? _____ How often? _____
Do you smoke? ❑Yes ❑No If yes, how much? _____
Have you had or have you been exposed to HIV (AIDS) ? ❑Yes ❑No

Please answer the following questions
(Women) Are you pregnant? ❑Yes ❑No Due Date ____/____/____

What is your occupation? _____ Hobbies? _____

Do we have permission to discuss your medical condition with family members? ❑ Yes ❑ No

If so, name_____ Relationship_____

Completed by ❑Patient
❑Medical Assistant _____ Initials

_____ Signed by Patient ____/____/____ Date

_____ ____/____/____

JOE M. LEHMAN, M.D.
MICHAEL LEHMAN, M.D.
DAVID LONG, M.D.
BRYAN D. HARRIS, M.D.

3715 21ST STREET
LUBBOCK, TX 79410
(806) 795-0617
FAX: (806) 795-0602

Lehman Dermatology Clinic
Professional Association

INFORMATION REGARDING YOUR FINANCIAL RESPONSIBILITY

PATIENTS WITH INSURANCE

Please read, sign and date at the bottom of the page

IF PRIVATE PAY/NO INSURANCE

Please check the box, read, sign and date at the bottom of the page

❑ PRIVATE PAY/NO INSURANCE

The total patient balance is required to be paid at the time services are provided. We accept cash, checks, VISA, MasterCard and Discover. ***WE DO NOT ACCEPT CARE CREDIT!!!***

Our office participates in various insurance plans. It is your responsibility to:

- Bring your insurance card to every visit.
- Be prepared to pay your copay, deductible and out of pocket at time of service.
- For medical care NOT COVERED under your insurance, 100% of payment is due at time of service.
- Any outstanding balances (owed by you or any family members you are responsible for) are to be paid at time of service.
- If we file a claim to an out-of-network plan as a courtesy, you will still be responsible to pay in full at time services are rendered.
- Payments for any unaccompanied minors (17 years or younger) are due at time of service.

If your insurance requires a referral, it is your responsibility to get that referral from your PCP prior to your appointment. If you do not have a referral, you may want to reschedule your appointment, or you will have to pay 100% of your visit.

Individual insurance companies determine in what situations deductibles will apply. In-office surgeries, procedures, biopsies, pathology fees, removal of pre-cancerous lesions and some injections may fall under your deductible and/or out of pocket. If you have questions as to what part of your visit falls under the deductible, please contact your insurance company prior to your visit.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY COPAY, DEDUCTIBLE AND/OR OUT OF POCKET AT THE TIME OF SERVICE. IF NO REFERRAL IS OBTAINED, I WILL PAY 100% OF MY VISIT.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

(MUST BE 18 YEARS OR OLDER)

*****PLEASE TURN OVER*****

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print)_____

Relationship to Patient_____

Signature_____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

*****PLEASE TURN OVER*****