Dermatology Specialists

2520 BROADWAY SUITE 202 SAN ANTONIO, TX 78215 P: 210-541-4884 F: 210-541-4900 WWW.DERMSOUTHTX.COM

DEMOGRAPHIC INFORMATION:

Name: _____ DOB: (mm/dd/yy) _____

Mailing Address: _____ Zip Code: _____

Home Ph: _____ Mobile Ph: _____

Email: _____ Preferred contact: Home Mobile Email

May we leave a detailed message? Yes No

Emergency Contact/Guardian: _____ Phone: _____

Relationship: _____

May we share medical information with this person? Yes No

Other family members or friends we can share medical information with:

Name: Relationship:

_____

_____

_____

Primary Physicians Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____

How did you hear about us? Friend/word of mouth Doctor Insurance Website

Facebook Other: _____

History and Intake Form Name: _____

Past Medical History: (please circle all that apply)

Anxiety	Arthritis	Asthma	Atrial fibrillation
Breast Cancer	Colon Cancer	COPD	Coronary artery disease
Depression	Diabetes	Kidney Disease	Hearing Loss
Hepatitis	High Blood Pressure	HIV/AIDS	High Cholesterol
Thyroid disease	Leukemia	Lung Cancer	Lymphoma
Prostate cancer	Radiation Treatment	Seizures	Stroke

NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Heart Valve Replacement
Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within 2 years
Kidney Removal (Right, Left)
Lung Removed: Cancer
Kidney Transplant
Kidney/Pancreas Transplant
Liver Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Cancer
Ovaries Removed: Preventive
Spleen Removed
Testicles Removed (Right, Left, Both)
Uterus Removed: Fibroids/Noncancer Biological Heart
Uterus Removed: Uterine Cancer
Prostate Removed: Cancer
Fracture Repair (ORIF)
Spinal Surgery/Fusion

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Seasonal allergies
Melanoma
Poison Ivy/Oak
Precancerous Moles
Psoriasis
Squamous Cell Cancer
Other Skin Cancer:
_____

NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Have you had a flu shot this year? Yes No

History and Intake Form Name: _____

Have you ever had a pneumonia shot? Yes No
Have you had a shingles shot? Yes No

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

FAMILY History (Only first degree relatives)

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Do you have a family history of nonmelanoma skin cancers? Yes No

If yes, which relative(s)? _____
Do you have a family history of other cancers? If yes, which relative and what kind of cancer?

_____

Do you have a family history of diabetes? Yes No Who?

_____

Other Family History (Only first degree relatives)

_____

_____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Defibrillator
Artificial joint replacement within 2 years
Blood thinners
Pacemaker
Require antibiotics prior to dental work
Rapid heart beat with epinephrine
Pregnant
Trying to become pregnant?
Recent travel to Ebola infected region?
MRSA?

History and Intake Form Name: _____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Fever/chills		
Rash		
Unintentional Weight Loss		
Swollen Lymph Nodes		
Nonhealing skin lesions		
Changing Mole		
Change in skin cancer scars (if present)		
Nausea		
Abdominal Pain		
Diarrhea		
Bloody Stool		
Bloody Urine		
Cough		
Shortness of breath		
Chest Pain		
Leg swelling/edema		
Burning, Stinging or Eye Pain		
Headaches		
Joint Pain or Swelling		
Immunosuppression		

Other Symptoms: _____

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Please read and initial each of our policies. If you have any questions we are happy to help you.

_____ **Payment Policy**: We will bill your insurance company if we are a participating (in network) provider. Ultimately you are responsible for payment for all services that are not covered by your insurance company. You will be expected to pay any copay or coinsurance, deductible, and outstanding balances due on or before the day of your scheduled appointment. An NSF fee of $25 will be assessed for all checks returned due to non sufficient funds.

_____ **Referrals**: If your insurance company requires that you have a referral from your primary care provider, you are responsible for ensuring that referral has arrived and is active prior to your appointment. We will try to assist you in obtaining that referral. If a referral is not available at the time of your appointment, we may ask you to reschedule your appointment.

_____ **Late Patients**: If you are more than fifteen minutes late for your appointment, you may be asked to reschedule.

_____ **Required Information**: If you are a new patient, we need to see a valid photo ID and your insurance card. At each appointment, we will ask you to confirm your insurance information, address, phone number, email address (if you have one) and your current medications. This is to ensure that we can reach you, can safely prescribe medications for you and correctly bill your insurance.

_____ **Cancelling/Rescheduling/No Showing Appointments**: Because we have many requests for appointments and patients often have to wait weeks to be seen, we ask that you provide us with at least 24 hours' notice for any cancellations or reschedules. That will allow us to use your appointment for someone else who needs it. If you do not provide us with that notice, you may be charged a $50 fee. For all surgical appointments you may be charged a $100 fee.

_____ **Prescription Refills**: Please call your pharmacy for any prescription refills. Allow 72 hours for any refills. If you have not been seen within a year, refills will not be called in. You will need an appointment to be seen first.

_____ **Biopsies and Excision Specimens**: If you have a biopsy or surgical removal performed, your skin sample will be sent to an outside pathology lab where a specially trained skin pathologist will process and review your tissue. This is a separate and necessary service and you will be billed for this service by the dermatopathology laboratory. Please direct any billing questions for this portion of your visit to the pathology laboratory. Because of the special nature of skin specimens and the expertise required, we exclusively use Sagis laboratories. Other laboratories, e.g. Quest or LabCorp are not options for these specimens.

_____ **Bloodwork**: We may rarely ask you to have blood samples drawn. We do not draw blood here but will instead refer you to a laboratory of your choosing. You will need to check with your insurance company to determine which labs and related bloodwork we order, is covered by your insurance.

_____ **Telephone Messages**: Because we are a small office and our call volume is high, you may reach our answering machine during business hours. Please do not hang up; instead, please leave a message and we will get back to you promptly. We check our messages throughout the day. Please allow 48 hours for return of a non-emergency call.

_____ **Biopsy Results**: A member of our staff will contact you within 7-10 business days with your results. If you do not hear from our office within 2 weeks please call.

_____ **Cosmetic Services**: Payment is always due at the time of service. You may use Care Credit if you prefer.

_____ **Children**: Children under 18 cannot be seen without a legal guardian present. We ask that you leave any children who are between the ages of 1 & 7 at home rather than bringing them with you to your appointment.

_____ **Cell Phone Usage**: As a courtesy to others, we ask that you step out of the office area to use your cell phone. We also ask that you turn off your cell phone once called for your appointment.

_____ **Patient Portal**: Please DO NOT use email to communicate with us, as email is not a HIPAA compliant means of communicating Protected Health Information (PHI). You will be provided Patient Portal information and credentials; we appreciate you using the Portal to communicate with us.

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____
Printed Name-Patient or Responsible Party

_____
Patient Signature or Responsible Party Date

_____
Relationship to patient (if other than patient)

Witness: _____
Printed Name-Practice Representative

_____ _____/_____/_____
Signature Date