New Patient Demographics

Patient Demographic Information

Patient Name (Last, First, Middle) _____ **Nickname** _____

SSN _____ **Birth Date** _____ **Age** _____ **Sex** _____

Address _____ **City, State, ZIP** _____

Home Phone _____ **Cell Phone** _____

Email Address _____

Emergency Contact Name _____ **Emergency Contact Phone** _____

Marital Status _____ **Race** _____ **Ethnicity** _____

Preferred Language _____ **Employer** _____

Primary Care Physician (Name, Address, Phone Number) _____

How did you hear about us: *Select one*

☐ Patient Referral ☐ Provider referral:_____ ☐ Insurance referral ☐ Web search

☐ Social Media ☐ Other:_____

Responsible Party Information (if different than above or if patient is a minor)

Guarantor Name (Last, First) _____ **Relationship** _____

SSN _____ **Birth Date** _____ **Sex** _____

Address _____ **City, State, ZIP** _____

Home Phone _____ **Cell Phone** _____

Email Address

Insurance Information

Primary Insurance	_____	**Secondary Insurance**	_____
Policy Holder Name	_____	**Policy Holder Name**	_____
Relationship to Patient	_____	**Relationship to Patient**	_____
Policy Holder DOB	_____	**Policy Holder DOB**	_____
Policy # / Member ID	_____	**Policy # / Member ID**	_____
Group #	_____	**Group #**	_____

Patient / Guarantor Signature _____ **Date** _____

Reason for Visit?_____

Preferred Pharmacy (Include Location)_____

☐Yes ☐No Do you drink alcohol? If yes, how many drinks per day? _____ Occupation _____
☐Yes ☐No Do you smoke? If yes, how many packs per day? _____
☐Yes ☐No Do you use recreational drugs? If yes, list _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

☐ Yes ☐ No	Anxiety	☐ Yes ☐ No	Hearing Loss
☐ Yes ☐ No	Artificial Joints	☐ Yes ☐ No	Hepatitis
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	High Blood Pressure
☐ Yes ☐ No	Atrial Fibrillation	☐ Yes ☐ No	HIV/AIDS
☐ Yes ☐ No	Cancer (non-skin)	☐ Yes ☐ No	High Cholesterol
☐ Yes ☐ No	COPD	☐ Yes ☐ No	Seasonal Allergies
☐ Yes ☐ No	Coronary Artery Disease	☐ Yes ☐ No	Seizures
☐ Yes ☐ No	Depression	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Thyroid Disease
☐ Yes ☐ No	End Stage Renal Disease	☐ Yes ☐ No	Valve Replacement

Other _____

SKIN DISEASE HISTORY

Please check all that apply

☐ Yes ☐ No	Actinic Keratosis
☐ Yes ☐ No	Basal Cell Skin Cancer
☐ Yes ☐ No	Melanoma
☐ Yes ☐ No	Squamous Cell Skin Cancer
☐ Yes ☐ No	Precancerous Moles (Atypical/Dysplastic)
☐ Yes ☐ No	History of bad or blistering sunburns?
☐ Yes ☐ No	Do you wear sunscreen? If yes, what SPF? _____
☐ Yes ☐ No	Do you have family history of Melanoma? If yes, who? _____

REVIEW OF SYMPTOMS

Are you currently experiencing any of the following?

☐ Yes ☐ No	Runny Nose/Itchy Eyes	☐ Yes ☐ No	Enlarged Glands/Lymph Nodes
☐ Yes ☐ No	Palpitations/Chest Pain	☐ Yes ☐ No	Joint Pains
☐ Yes ☐ No	Leg Swelling	☐ Yes ☐ No	Muscle Aches
☐ Yes ☐ No	Fever/Chills	☐ Yes ☐ No	Headaches
☐ Yes ☐ No	Unplanned Weight Loss	☐ Yes ☐ No	Memory Loss
☐ Yes ☐ No	Cold/Heat Intolerance	☐ Yes ☐ No	Depression
☐ Yes ☐ No	Excessive Thirst/Hunger	☐ Yes ☐ No	Anxiety
☐ Yes ☐ No	Swallowing Problems	☐ Yes ☐ No	Wheezing/Asthma
☐ Yes ☐ No	Mouth or Cold Sores	☐ Yes ☐ No	Shortness of Breath
☐ Yes ☐ No	Nausea/Vomiting	☐ Yes ☐ No	Suppressed Immune System
☐ Yes ☐ No	Diarrhea/Constipation	☐ Yes ☐ No	Rash with Medication or Foods
☐ Yes ☐ No	Burning with Urination	☐ Yes ☐ No	Problems Healing
☐ Yes ☐ No	Blood in Urine	☐ Yes ☐ No	Scars/Keloids After Surgery

☐ Yes ☐ No Do you have immediate family with a history of Skin Disease? If yes, who/type? _

☐ Yes ☐ No Do you have immediate family with a history of Skin Cancer? If yes, who/type? _

PAST SURGICAL HISTORY

Please list previous surgical procedures

_____
_____
_____
_____
_____

ALLERGIES

Please list all allergies and reactions

_____
_____

MEDICATIONS

Please list all current medications (OTC, Herbal, Etc.)

_____
_____
_____
_____
_____

ALERTS

Are you currently experiencing any of the following?

☐Yes ☐No	Allergy to Latex or Tape	☐Yes ☐No	Allergy to Lidocaine	☐Yes ☐No	Allergy to Topical Antibiotic
☐Yes ☐No	Artificial Heart Valve	☐Yes ☐No	Artificial Joint in Past 2 Months	☐Yes ☐No	Accutane Used In Past 6 Months
☐Yes ☐No	Blood Thinner Use/Daily Aspirin	☐Yes ☐No	Defibrillator	☐Yes ☐No	Pacemaker
☐Yes ☐No	Medication Prior to Procedures	☐Yes ☐No	Rapid Heart Rate w/ Epinephrine	☐Yes ☐No	Pregnant
☐Yes ☐No	MRSA (Resistant Staph)			☐ Yes ☐ No	Breastfeeding

EDUCATE YOURSELF

Our physicians are experts in Cosmetic Dermatology procedures! Please help us maintain the highest level of customer service by checking all areas that interest you:

☐ Botox	☐ Laser Hair Reduction	☐ Skin Care Advice
☐ Cosmetic Fillers	☐ Spider Vein Treatment	
☐ Neck Rejuvenation	☐ Facial Redness	
☐ Chemical Peels	☐ Sun Spots	
☐ Acne Scarring	☐ Body Contouring	

Patient/Guardian Signature:_____ Date:_____

ACKNOWLEDGMENT OF OFFICE POLICIES

Please review and sign after reading each policy listed below

General Patient Authorization: I hereby authorize providers of Texas Dermatology Associates, P.A. to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

Receipt of Notice of Privacy Practices: Texas Dermatology Associates, P.A. Notice of Privacy Practices provides information about how Texas Dermatology Associates, P.A. may use and disclose protected health information about me. The Notice of Privacy Practices contains a Patient Rights section describing my rights under the law. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of Texas Dermatology Associates, P.A. Texas Dermatology Associates, P.A. reserves the right to change the Notice of Privacy Practices.

Cancellation Policy: If a patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Texas Dermatology Associates, P.A. reserves the right to charge a $50 fee if a patient does not cancel his/her appointment within 24 hours. Administrative fees incurred for failure to provide cancellation notice are not billable to insurance or any other third party payor. These policies include appointments with all providers.

Release of Medical Information:

☐ **I do** ☐ **do not** (*select one*) authorize Texas Dermatology Associates, P.A. and its designated representatives to release my medical information to my primary care physician. If authorized, please provide name of physician: _____.

If at any time you should need a copy of your medical records, we require a written release to be signed and dated. The form is available at our front desk. Please allow up to 15 business days to complete your request. If your request is urgent, please mark the request as urgent and someone from our staff will contact you to expedite your request. Absent providing a secure fax number, records must be MAILED to your address of record. Copies of blood work and pathology reports are provided at no charge, copies of your complete medical record or office notes will require $25 fee.

Texas Dermatology Associates, P.A. requires a written records release form to transmit records to any physician or medical organization that is not listed as your referring physician. If you have a consulting physician you would like to have listed as an authorized recipient of your medical information, please request and complete a release form for each physician you wish to receive your records.

Contact Permission: In the event that Texas Dermatology Associates, P.A. needs to contact you (the patient), regarding an appointment, lab result, medication, or any other reason, it is permissible to:

☐ **Yes** ☐ **No** (*select one*) Leave a message with confidential clinical information on an answering machine/voicemail .

☐ **Yes** ☐ **No** (*select one*) Speak with other authorized individuals listed below.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

☐ **Yes** ☐ **No**(*select one*) **Send a text message to the following number:** _____

☐ **Yes** ☐ **No** (*select one*) **I would like to receive information about special offers, coupons, and events at Texas Dermatology Associates, P.A. and Menter Cosmetic Institute.**

☐ **Yes** ☐ **No** (*select one*) **I have psoriasis and would like to be considered for a clinical trial, you may be offered compensation for your time and travel. For more information you may visit wwww.menterderm.com**

Expiration of and Right to Revoke Authorization to Disclose Protected Health Information: I understand that I can withdraw my permission set forth above at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Release of Medical Information" and "Contact Permission". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

The duration of this authorization is valid until the earlier to occur of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional): *Month:* _____ *Day:* _____ *Year:* _____.

ACKNOWLEDGMENT OF OFFICE POLICIES

Physician Assistant & Residents: Texas Dermatology Associates, P.A. may staff physician assistants and residents to assist in the delivery of medical dermatology care. A physician assistant ("PA") is not a doctor but is a graduate of a certified training program and is licensed by the Texas Physician Assistant Board. Under the supervision of a physician, a PA can diagnose, treat, and monitor common acute and chronic diseases. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing their work. Residents are physicians who completed medical school and are receiving specialized training in dermatology. Residents can diagnose, treat, and monitor common acute and chronic diseases under the supervision of a physician. I understand that at any time I can request to see a physician. I have read the above and hereby consent to the services of a PA or resident for my health care needs.

Unaccompanied Minors (Under 18 Years Old): New patients who are minors must have a parent or legal guardian present for the new patient visit. Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. Should you wish for us to see your teen/young adult child when they arrive at the office unaccompanied please read, indicate and sign below:

☐ **YES** ☐ **NO** (*select one)* I hereby grant the physicians and providers at Texas Dermatology Associates, P.A. permission to treat my child when they arrive at the office unaccompanied. I understand this may include changes in current therapy my child is receiving including treatments or minor skin surgery.

Signature: _____ Date: _____

Medication History:

☐ **YES** ☐ **NO** (*select one)* Texas Dermatology Associates, P.A. has joined a pharmacy hub network which will enable us to receive your last two years' of medicaiton history for drugs prescribed to you through electronic processing. It will not include every medicine you take- over the counter items, and items not paid through your pharmacy insurance benefit are omitted. This service will improve your health records. If you agree to have us request this information, plesae mark "yes". If not, please mark "no".

Proof of Identity: Texas Dermatology Associates, P.A. requires proof of identity on file. I understand that I will be asked to provide a photo ID such as a driver's license at check-in. This will be scanned into your private medical record as a means to document who we are treating.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

_____ _____

Signature of Patient or Guardian **Date**

_____

Relationship

FINANCIAL POLICY NOTICE

Thank you for choosing Texas Dermatology Associates, P.A. Please understand that the services you elect to participate in imply a financial responsibility on your part, and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit, please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that they fully understand their benefits and coverage. We accept cash, checks, MasterCard, Visa, Discover, American Express and CareCredit.

Please review and sign after reading each policy listed below

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service.

Policy Benefits / Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Texas Dermatology Associates, P.A. of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect my coverage. I understand that I am responsible for any amounts not covered by my insurer. Routine in-office procedures, including but not limited to, biopsies, injections, destruction of precancerous and non-cancerous growths and surgical removal and repair of cancerous and non-cancerous growths are billed separately from my office visit and may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance companies may require for payment.

Copayments: I understand that all copays are due at the time of my appointment and before I see the provider. Given that Texas Dermatology Associates, P.A. physicians are specialists, a higher copay may be required.

Deductibles: I understand that if it is determined that my insurance policy has an unmet deductible, payment for services at the contracted rate between Texas Dermatology Associates, P.A. and my insurer will be due at the time of service.

Managed Care (HMO) Plans or Health Select: I understand it is my responsibility to obtain any and all necessary referrals including referrals for follow up visits if my plan requires one. Texas Dermatology Associates, P.A. will strive to keep me informed of visits remaining on a referral and/or the expiration date but it is ultimately my responsibility to know this information and to make the necessary arrangements through my primary care physician. I understand that failure to obtain a referral, if required by my insurance for coverage, will result in me bearing complete financial responsibility for any and all services received.

Benefit Representation: I understand that the staff of Texas Dermatology Associates, P.A. will make every effort to accurately verify my insurance benefits but I will not solely rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them.

Assignment of Benefits: I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at Texas Dermatology Associates, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance or Medicare. I further agree to pay for any items or services not covered by insurance or Medicare, as applicable. I hereby authorize the Texas Dermatology Associates, P.A. to release all information necessary to secure all payments or approvals of benefits.

Payment for Ancillary Services (Laboratory/Pathology): I understand that Texas Dermatology Associates, P.A. utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill for services separately from Texas Dermatology Associates, P.A. I acknowledge that payments made to Texas Dermatology Associates, P.A. are for services rendered by Texas Dermatology Associates, P.A. and authorize the use of outside laboratories as deemed necessary and warranted by my provider(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Cosmetic Procedures: I understand that cosmetic procedures are not covered by insurance and I am fully responsible for payment.

Returned Checks: I understand that checks presented to Texas Dermatology Associates, P.A. as payment for services rendered and subsequently returned by my bank for any reason as unpaid will be charged a returned check fee of $25. Balances must be handled by cash, credit card or money order. Texas Dermatology Associates, P.A. reserves the right to represent returned checks electronically for their face value plus the returned check fee.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter. I acknowledge that I must contact Texas Dermatology Associates, P.A. before this time if I wish to make other payment arrangements.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

Signature of Patient or Guardian/Guarantor _____ **Date** _____

Relationship _____

Communicator our Patient Portal

Name: _____
Date of Birth: _____

Communicator is a secure web patient portal on our website home pages that gives you, our patient, a new and efficient internet-based method of communicating with our practice. Patients can log on to our website www.texasderm.com and:

1. Exchange messages wiht our practice
2. Review and pay billing statements
3. Research health topics
4. Request appointments
5. Retrieve Test Results
6. Review Personal Health Information
7. Complete and Update Medical Forms
8. Update your profile and contact information
9. View a summary of your most recent office visit

It is simple and easy to access your patient portal:

1. Log onto our website at www.texasderm.com
2. Click on the Existing Patient Link
3. Register: The phone number you enter must match the primary number we have on file for you at Texas Dermatology Associates, P.A. This would be the phone number (home or mobile) that you provided for us to call as your primary contact number. For security purposes, you will receive a phone call from Athena at your primary contact number before you will be able to complete your registration. Therefore, you should have this phone accessible when you start the registration process.

If you experience difficulty when registering, please call our office during normal business hours for assistance.
(972) 386-7546