TYPE OF VISIT:
☐ **New Patient** ☐ **Follow up** ☐ **Cosmetic Services**

Dallas Dermatology Partners

DEMOGRAPHIC INFORMATION

Name: ______________________________ **DOB:** ___/___/_____ **AGE:** _____ **Social Security:** ______________________________

Last First Middle Initial

Address:____

Number Street City State Zip

Cell Phone:_____________________ Home Phone:____________________EMAIL**:** ________________________

Who referred you to our office? ______________________ Phone Number **:** ______________________

Who is your primary care doctor? ______________________ Phone Number **:** ______________________

Emergency Contact? ____________________________ Phone Number: ______________________

☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Other: ___________

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic/Non-Latino ☐ Other/ Non-determined
Languages Spoken: ☐ English ☐ Spanish ☐ Other: ______________________________

Occupation:_______________**Employer:**__________________**Phone:** ______________________

Preferred Pharmacy: ____________________________ **Phone:**____________________________

Preferred Pharmacy Address: ____

INSURANCE INFORMATION

Primary Insurance:_____________________**Subscriber ID #**______________________ **Group #** _______
Primary Card Holder: ☐ Self *or* ☐ Spouse ☐ Parent ☐ Other: ______________________

Co-Pay: $______ ________________________/________________________

Name of Policy Holder Date of Birth of Policy Holder

Secondary Insurance:___________________**Subscriber ID #**______________________ **Group #** _______
Secondary Card Holder: ☐ Self *or* ☐ Spouse ☐ Parent ☐ Other: ______________________

________________________/________________________

Name Of Policy Holder Date of Birth of Policy Holder

Besides regular mail, I authorize Dallas Dermatology Partners to contact me by the following methods: (please checkboxes)

☐ **Cell phone** ☐ **Text messaging** ☐ **Home phone** ☐ **Email**

Are you interested in hearing more about our SPA cosmetic services? ☐ **Yes** ☐ **No**

PATIENT NAME:____DATE: ____________________________________

RELEASE OF INFORMATION TO OTHERS (HIPPA)

I acknowledge that I have received a copy of "Notice of Privacy Practices". I authorize Dallas Dermatology Partners and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

□ All information including specific medications and dosages, lab results and information related to sensitive issuessuch as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

□ **No information whatsoever**

To whom can we release information (please list names):

□ ____
Name Phone# Relationship to Patient

□ ____
Name Phone# Relationship to Patient

□ **No one except the patient can obtain information.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do soin writing that the revocation will not apply to information already released in response to this authorization.

2.____ ____
Signature of Patient/Guardian Date

TREATMENT CONSENT AND AUTHORIZATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcareprofessionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill and a means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence ofhealthcare professionals.

I hereby authorize Dallas Dermatology Partners to furnish to any designated attorney or insurance Company all information necessary to file a health insurance claim form, or to obtain reimbursement. *I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Dallas Dermatology Partners.*

I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to Dallas Dermatology Partners. I understand that this facility will maintain medical records in accordance with state requirements. By my signature below, you are fully authorized to disclose such information when requested by Dallas Dermatology Partners.

The foregoing information is true and correct to the best of my knowledge. I authorize Dallas Dermatology Partners toprovide medical treatment to me in the office or in the hospital.

3.____ ____
Signature of Patient/Guardian Date

FINANCIAL AND GENERAL POLICY SIGNATURE

I have read and understand the Dallas Dermatology Partners Financial and General Office Policies. My signature indicates compliance and understanding of these policies and that I have completed all the forms to the best of myknowledge.

4.____ ____
Signature of Patient/Guardian

Dallas Dermatology Partners Financial Policy

We are honored to be your dermatologic provider.
We know you have a choice and appreciate your trust.

Please be aware of the following:

- Patients are responsible for payment at the time of service. We accept most forms of payment
- Patients should be prepared to pay their copay and any applicable co-insurance for dermatologic procedures. Most dermatologic procedures go toward your deductible. Should you be due a refund, we will make every effort to refund within 30 days.
- Should your health plan determine a service uncovered, you will be responsible for the complete charge.
- Please make sure to update your insurance information in the event you have a change of insurance.
- Lab fees may be billed separately from an off-site lab
- Cosmetic services are considered a patient expense and are not billed to insurance.
- We will make every effort to work with you regarding any need for financial arrangements

Procedure Pricing List

Most dermatology procedures will be applied towards your insurance deductible/co-insurance. Please be aware that if in your visit with Dallas Dermatology Partners you have any of these procedures done, we will collect an estimated payment for them at the time of service. Should your insurance pay a portion or in full for these procedures, we will refund you upon receipt of your insurance payment.

Below is a list of the most common procedures in this office that will apply to your deductible/co-insurance

Common Procedures	**Estimated Cost Range**
- Biopsy of skin lesion	
o Shave method (one lesion)	$115.00
o Each additional lesion(s)	$63.00
o Punch method (one lesion)	$150.00
o Each additional lesion(s)	$75.00
- Destruction of wart or molluscum	$135.00
- Destruction of actinic keratosis/actinic keratoses	$75.00-$250.00
- Surgical repair of skin lesions	$380.00-$450.00
- Excision of Skin Lesions	$150.00-$460.00

___________________________________ _______________________

Name of Patient Date

___________________________________ _______________________

Signature of Patient or Responsible Party Date

Date: _________________

Medical Questionnaire

Name________________________________ DOB_______________________________ Age____________

Preferred Pharmacy: __________________________________ Phone:_________________________________

Preferred Pharmacy Address: ____

Medical History: Reason for visit: ____
How long have you had this problem? ____
Symptoms (How does it bother you?) ____
Treatments you have tried:____

Please list all MEDICATIONS (with dosing) that you are taking including over the counter medications:

Please list any MEDICATIONS you are allergic to: ____

Medical problems (check if yes)___Diabetes ___High Blood Pressure ___Heart disease ___Pacemaker
___Artificial joint/valve ___Asthma ___other Lung disease ___Thyroid disease
___Hepatitis, type ___ ___HIV ___other Liver disease ___Autoimmune Disease
___Cancer, type___ ___Depression ___Kidney Disease ___Transplantation
___Other (comments):____

Past Surgeries/Other Medical problems ____

***Female Patients*: Pregnant/trying to get pregnant?**__ yes __ no (___ weeks) Breastfeeding? ___ yes ___ no

History of Skin Cancer? ____yes ____no: Melanoma ____Basal cell carcinoma ____Squamous cell carcinoma

Area of body:_____________________________How treated:____

History of Skin Disease, past or current: ____

Alerts: Please Check all that apply

__ Allergy to Adhesive __ Allergy to Lidocaine __Allergy to Topical Antibiotics

__ Artificial Heart valve __ Artificial Joint Replacement in the last 2 years __ Require antibiotics prior to surgical procedures

__ Blood thinners __Defibrillator ___ Pacemaker

Past Family and Social History:

Is there a family history of (please circle): melanoma, non-melanoma skin cancer

Have you ever had a blistering sunburn? ___ yes ___ no

Have you ever used tanning beds? ___ yes ___ no If yes, how long? _________________

Are you a ___ Current Smoker ____Past smoker ___ Never Smoker

Alcohol Use: __ None ___Less than 1 drink/day ___1-2 drinks/day ___3 or more drinks/day

History of past IV drug abuse or recreational drug use? ___Yes ___No

When was your last flu shot? _______________

Have you ever had the pneumonia vaccine? ____Yes ____No if *YES*, when? _________