

Patient Information Sheet
PLEASE COMPLETE ALL INFORMATION

Date ___/___/___ Payment by Cash Check Credit Card Gift Certificate Insurance carrier

Patient FULL NAME ___/___/___ Maiden name ___ Date of Birth ___

Address ___ City ___ State ___ Zip ___ Sex M. F. ___ Age ___

E-mail address ___ Phone numbers: Home (___) ___ Cell(____) ___

Work (___) ___ Ext. ___ Patient Occupation ___ Employer Name ___

Employers Address ___ City ___ State ___ Zip ___

Spouses Full Name ___ Spouses Employer ___ Spouses Phone ___ Ext. ___

IF PATIENT IS A MINOR (UNDER 21) Responsible Party ___ Relationship ___

Name ___ D.O.B. ___ Employer ___

Phone Home: (___) ___ Cell (___) ___ Work (___) ___ ext. ___

I have no insurance coverage I have insurance, but you are not a participating provider Medicare

New insurance rules state we must provide insured/ patients full name. Please do not use initials or nicknames

PRIMARY INSURANCE COMPANY ___ **Address** ___

Group Name ___ **Issuer** ___ **Payor #** ___ **Account #** ___

Effective Date ___ **Exact Name of Policy Holder** ___

Policy Holders Social Security number ___ **Patients** Social Security Number ___

Co-pay amount (for office visits only) ___ Deductible amount for *any* office procedure ___

Benefit Phone Number (___) ___

Our office policy requires that you provide us with your driver's license or state issued I.D. and your insurance card if applicable

Most insurance policies require that you meet an annual deductible if you are getting any type of procedure performed. Example: moles removed, biopsy, acne treatment, etc. You will be asked to satisfy that deductible amount at the time of service plus your usual co-pay. Initial ___

We charge \$35.00 for returned checks. Initial ___

Returned checks are turned over to the District Attorneys after 10 days. Initial ___

Missed appointment charge (without calling 4 hours prior to appointment) \$50.00 Initial ___

All surgical procedures/ laser appointments/ require a non-refundable deposit to hold time slot open Initial ___

Absolutely no cell phones can be used past the waiting room area. Some cell phones interfere with our laser computer systems and are very costly to have recalibrated.

We turn over uncollectible debt to the proper credit agency

BRIEF MEDICAL HISTORY

Date _____

Name (please print): _____

A. What is your skin problem? (rash, growth, acne, warts, hair loss, scars, etc. Please limit to 2 skin problems per visit.

B. When did you first notice this problem? _____

C. Please draw circles on the figure on the reverse where your skin problem is located.

D. What medications have you been given by a doctor for it? Please list all medications past & present.

E. Have you put anything on your skin yourself? Please list everything you used for the last 6 months for this condition.

Please circle "yes" or "no" and answer the following:

1. Have you had any other skin problems? Example Skin Cancer, Premalignant Lesion, Eczema, etc. Please list and be specific. yes ___ no ___

2. Has a doctor given you anything or have you used anything yourself for these skin problems? yes ___ no ___
If yes, please list them all.

3. Does anyone in your family have skin problems, rashes, allergies, asthma, hay fever? yes ___ no ___
If yes, circle which ones.
4. Are you allergic to any medicine? (penicillin, sulfa, codeine, local anesthetics, etc.) yes ___ no ___
If yes, please print.

- 5.. Does anything that touches your skin cause a rash or allergy? (poison ivy, jewelry, etc.) yes ___ no ___
If yes, please list.

- 6.. Are you now being treated by a doctor for any reason? (be specific) yes ___ no ___
If yes, for what.

- 7.. List all pills, medicines, vitamins, etc. you take regularly or occasionally. (this is very important)

- 8.. Please list any surgeries you have had.

- 9.. Have you ever had eczema, hives, asthma, or easy bleeding? yes ___ no ___
- 10.. Is there anything else I should know about your health? yes ___ no ___
(surgery, diabetes, stomach ulcers, high blood pressure, heart condition, pacemaker)
- 11.. Are you HIV positive? yes ___ no ___
- 12.. For Women: Initial here _____
 - Have you had a hysterectomy? yes ___ no ___
 - When? _____
 - Are you pregnant? yes ___ no ___
 - Are you taking hormone or birth control pills? yes ___ no ___
 - If you have previously, when did you stop? _____
 - If you have acne, is it affected by your menstrual cycle? yes ___ no ___

Condensed version of our HIPAA Policy:

We are bound by law to explain to our patients what we do with their private medical information under the HIPAA law. We are providing you with the short version. The actual HIPPA law is approximately 400 pages long. We have a copy of the law in the office for inspection, or you may go to www.hipaa.org and download it for further inspection.

1. We have implemented all known standards for claims transmissions to protect your privacy. You need to sign here authorizing us to file your insurance claims.

Name: _____ Address _____

We will leave you messages on your home phone, cell phone or by email regarding your appointments or general information you have requested from us unless you tell us otherwise.

2. We keep your records in a paper chart on the premises. We do NOT keep anyone’s medical records on the web. We do not discuss any aspect of medical information with family members unless you give us written consent to do so.

We will discuss your medical condition with a referring doctor if the need arises.

3. If you want your records transferred to another doctor’s office, you will need to provide us with a signed authorization.

4. You must initial this line in order for us to have permission to call in your prescriptions to your pharmacy. Please provide your pharmacy number. _____ Please initial _____

6. We will continue to keep your medical information completely private, as we have done for the past 25 years unless you specifically request otherwise in writing.

7. We are required to keep a picture I.D. and your social security number on file

8. We have absolutely no control with what your insurance company does with your medical information once your claims have been filed. We have no control with what your pharmacy does with your information. They will provide that information to you. Be sure to read it thoroughly.

9. Please initial here ___ that you have read this disclosure.

10. This line is provided for you to give us any specific requests regarding your medical chart.

Explanation of Pathology Billing Procedures:

We are required to send all biopsies to the pathologist. You will receive a separate bill from the laboratory (National Dermatopathology Labs) Lake Balboa, California (888) 882-0077. Please be sure you have provided us with all of your insurance information even though we may not be a participating provider so that the lab can file your insurance. Make sure we get a copy of your insurance card before you leave the office.

Although there is a standard fee for one biopsy, additional costs may be incurred if multiple biopsies were taken or if additional studies needed to be done. Also be aware your insurance may decide that removal of your particular lesions were not medically necessary and they may not pay at all. We have absolutely no way of knowing which ones your insurance will or will not cover.

The pathologist is a completely different entity from Dermatology Associates of Dallas. If you receive a bill from National Dermatopathology Labs and have not provided your insurance information to us, you will need to call them directly at (888) 882-0077.

Payment Policy:

Full payment is expected at the time of service. We accept cash, all major credit cards, approved checks and money orders. We currently are providers for PHCS, Texas Tru Choice, Great West and PacifiCare. We do not accept any form of HMO’s or Medicare. We are not a participating provider for Medicare however; we will accept new Medicare patients and we will file all necessary Medicare forms. In some cases Medicare will not cover the entire bill and the remainder is billed to the Medicare patient. In most cases this is about \$5.00 to \$15.00. At your request we can keep your credit card information on file to be used by your children.

Please do not ask us to perform cosmetic procedures and then file them with your insurance company. We can not and will not do that. A few examples are removing asymptomatic moles, leg veins, Botox, etc.

Your signature states that you have read and understand our policies _____

Date ___/___/_____

Phone: 214.691.6999

1.800.346.3713

Fax: 214.691.7902




Presbyterian
Hospital

Walnut Hill Lane



American Heart Association

Phoenix



Dermatology Assoc.of Dallas
7150 Greenville Ave. Ste. 100
Dallas, Texas 75231

Greenville Ave.

Park Lane