Name: _____ **Date of birth**: _____ **Date:** _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Do you have a healthcare proxy? Yes No If yes, name and phone number: _____

Do you have a living will? Yes No

Chief Complaint

What is the reason for your visit today? _____

What are your symptoms? _____

What area(s) is affected? _____

How long have you had the problem? _____

What have you used to treat the problem? _____

Medical Information

Select any of the following medical conditions that you currently have: OR ( ) none applies to me

( ) Anxiety	( ) COPD(Chronic Obstructive Pulmonary Disease)	( ) Hypertension(High Blood Pressure)	( ) Prostate Cancer
( ) Arthritis	( ) Coronary Artery Disease	( ) HIV/AIDS	( ) Radiation Treatment
( ) Asthma	( ) Depression	( ) Hypercholesterolemia	( ) Seizures
( ) Atrial Fibrillation(Irregular Heart Beat)	( ) Diabetes	( ) Hyperthyroidism	( ) Stroke
( ) Bone Marrow Transplant	( ) End Stage Renal Disease	( ) Hypothyroidism	( ) Other:_____
( ) BPH(Benign Enlargement of the Prostate)	( ) Gerd(Gastro esophageal Reflux Disease)	( ) Leukemia	
( ) Breast Cancer	( ) Hearing Loss	( ) Lung Cancer	
( ) Colon Cancer	( ) Hepatitis, Type:_____	( ) Lymphoma	

When was your last Flu shot? _____ Have you had a Pneumonia Vaccine? YES NO

Past Surgeries

List all previous surgeries OR ( ) none applies to me:

_____ _____ _____

_____ _____ _____

Skin History

Have you had any of the following skin conditions? OR ( ) none apply to me

( ) Acne	( ) Dry skin	( )Poison Ivy
( ) Actinic Keratosis	( ) Eczema	( ) Precancerous Moles
( ) Asthma	( ) Flaking or itchy scalp	( ) Psoriasis
( ) Blistering sunburns	( ) Hay fever/allergies	( ) Other:_____

Personal History of Skin Cancer	**Personal History of Sun Exposure**	**Family History of Skin Cancer**
( ) Basal Cell Carcinoma	Do you wear sunscreen daily? ( ) Yes ( ) No	( ) Basal Cell Carcinoma
( ) Squamous Cell Carcinoma	If yes, what SPF?_____	( ) Squamous Cell Carcinoma
( ) Melanoma	Do you tan in a tanning salon? ( ) Yes ( ) No	( ) Melanoma
( ) Unsure	Multiple blistering sunburns as a child? ( ) Yes ( ) No	( ) Skin cancer, unsure what type
( ) No History of Skin Cancer	History of atypical moles? ( ) Yes ( ) No	**If yes, which family member?**_____
		( ) No family history of skin cancer

Medication History

List all current medications and vitamins:

_____ _____ _____

_____ _____ _____

List **allergies to prescription** and **non-prescription medicines**:

_____ _____ _____

_____ _____ _____

Social History

( ) Never smoked
( ) Never drink alcohol
( ) Current smoker
( ) Drink socially (<1 daily)
( ) Quit, former smoker
( ) Drink Daily (1+ daily)

In the past year, how many times have you had five or more drinks in a day? _____

Review of Systems and Alerts

Please check **YES** or **NO** in the box provided for all symptoms you are **CURRENTLY EXPERIENCING**.

Hematologic/Lymphatic	**□ No to All**	**Endocrine**	**□ No to All**	**Gastrointestinal**	**□ No to All**
Problems with Bleeding	□ No □ Yes	Thyroid Problems	□ No □ Yes	Nausea or Vomiting	□ No □ Yes
Swollen Glands	□ No □ Yes	Excessive Thirst	□ No □ Yes	Heartburn	□ No □ Yes
Tender Glands	□ No □ Yes	**Eyes**	**□ No to All**	Increasing Constipation	□ No □ Yes
Anemia	□ No □ Yes	Redness	□ No □ Yes	Persistent Diarrhea	□ No □ Yes
Transfusion	□ No □ Yes	Pain	□ No □ Yes	Blood in Stool or Black Stool	□ No □ Yes
Integumentary - Skin	**□ No to All**	Double Vision	□ No □ Yes	Tightness or Abdominal Pain	□ No □ Yes
Problems with Healing	□ No □ Yes	Blurred Vision	□ No □ Yes	Jaundice	□ No □ Yes
Problems with Scarring	□ No □ Yes				
Easy Bruising	□ No □ Yes	**Ears/Nose/Mouth/Throat**	**□ No to All**	**Genitourinary**	**□ No to All**
Redness	□ No □ Yes	Ringing in Ears	□ No □ Yes	Pain/Burning on Urination	□ No □ Yes
Rash	□ No □ Yes	Runny Nose	□ No □ Yes	Blood in Urine/Cloudy	□ No □ Yes
Hives	□ No □ Yes	Sores in Mouth	□ No □ Yes	Smoky Urine	□ No □ Yes
Itching	□ No □ Yes	Dryness in Mouth	□ No □ Yes	Discharge from Penis/Vagina	□ No □ Yes
Sun Sensitive	□ No □ Yes	Frequent Sore Throat	□ No □ Yes	Getting up at Night to pass Urine	□ No □ Yes
Tightness	□ No □ Yes	Difficulty Swallowing	□ No □ Yes	Vaginal Dryness	□ No □ Yes
Nodules/Bumps	□ No □ Yes	Hoarseness	□ No □ Yes	Rash/Ulcers in Genital Area	□ No □ Yes
Hair Loss	□ No □ Yes				
Color Changes - Hands/Feet	□ No □ Yes				

Allergic/Immunologic	**□ No to All**	**Cardiovascular**	**□ No to All**	**Musculoskeletal**	**□ No to All**
Frequent Sneezing	□ No □ Yes	Sudden onset Chest Pain	□ No □ Yes	Morning Stiffness	□ No □ Yes
Susceptibility to Infection	□ No □ Yes	Sudden Changes of Heart Beat	□ No □ Yes	Joint Pain	□ No □ Yes
Immunosuppression	□ No □ Yes	High Blood Pressure	□ No □ Yes	Muscle Weakness	□ No □ Yes
Hay Fever	□ No □ Yes	Swollen Legs or Feet	□ No □ Yes	Muscle Tenderness	□ No □ Yes
				Joint Swelling	□ No □ Yes
Constitutional	**□ No to All**	**Respiratory**	**□ No to All**	**Neurological/Psychiatric**	**□ No to All**
Fever, Chills or Shakes	□ No □ Yes	Cough	□ No □ Yes	Headaches	□ No □ Yes
Night Sweats	□ No □ Yes	Shortness of Breath	□ No □ Yes	Dizziness	□ No □ Yes
Unintentional Weight Gain	□ No □ Yes	Wheezing	□ No □ Yes	Fainting	□ No □ Yes
Unintentional Weight Loss	□ No □ Yes			Anxiety	□ No □ Yes
				Depression	□ No □ Yes
				Agitation	□ No □ Yes

ALERTS		**ALERTS**		**ALERTS**	
Allergy to Adhesive	□ No □ Yes	Artificial Heart Valve	□ No □ Yes	Pacemaker	□ No □ Yes
Allergy to Lidocaine	□ No □ Yes	Artificial Joints within 2 Years	□ No □ Yes	MRSA/Staph	□ No □ Yes
Allergy to Antibiotic Ointments	□ No □ Yes	Blood Thinners	□ No □ Yes	Premedication Prior to Procedures	□ No □ Yes
History of Blood Clots	□ No □ Yes	Defibrillator	□ No □ Yes	Rapid Heartbeat with Epinephrine	□ No □ Yes

Pregnancy and Childbearing Information for Women Only			
Are you pregnant?	□ No □ Yes	Planning to become pregnant soon?	□ No □ Yes
Are you breastfeeding?	□ No □ Yes	Are you on some form of birth control? If yes, what form? _____	□ No □ Yes

NDA North Dallas DERMATOLOGY ASSOCIATES

PATIENT REGISTRATION

Please Complete All Fields

Date: _____

Patient Name: _____ **Date of Birth**: _____ **Marital Status**: _____
First *Last*

Address: _____ **City**: _____ **State**: _____ **Zip**: _____
Street/Apt #/PO Box

***Preferred Phone#**: ( ) Home: _____ ( ) Cell: _____ ( ) Work: _____

Email: _____ **Sex**: F M **SSN**: _____ **Preferred Language**: _____

Race: ( ) White ( ) Black/African American ( ) Asian ( ) American Indian or Alaska Native ( ) Native Hawaiian/Pacific Islander

( ) Other: _____

Ethnicity: ( ) Hispanic ( ) Non-Hispanic/Non-Latino ( ) Other/Non-determined

Referred by: ( )*****Physician ( ) Patient-to-Patient ( ) Family ( ) Insurance ( ) Internet ( ) Other: _____

***If referred by physician please give name**: _____ Phone: _____
First *Last*

Who is your Primary care Physician? _____ Phone: _____
First *Last*

Your visit today may include labs, cultures and/or skin biopsies. We generally receive results of lab work/cultures in approximately 3-5 business days and skin biopsy results in 7-10 business days. We will call you with results and any additional information prescribed by your physician. For **BENIGN/NEGATIVE** *results on any tests listed above:*

( ) **YES,** you may leave a detailed message informing me of my results at the following telephone # _____

( ) **NO,** do not leave a detailed message. Please leave call back information only on my voicemail.

Employer: _____ **Occupation**: _____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Home #:_____ Cell #:_____ Work #:_____

Person Responsible for Payment or Insurance subscriber (*If different from above*)**:**

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____
Street/Apt #/PO Box

Home #:_____ Cell #:_____ Work #:_____

Email: _____ SSN#:_____ Date of Birth: _____

Primary Insurance Co.:_____ Phone #:_____ Policy #_____ Group #:_____

Secondary Insurance Co.:_____ Phone #:_____ Policy #_____ Group #:_____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I hereby acknowledge that I have received a copy of North Dallas Dermatology Associates Notice of Privacy Practices. I have been given the opportunity to review, understand and consent to this practice's Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

_____ _____

Printed Name of Patient *Date*

_____

Signature of Patient or Legal Representative (if applicable)

Relationship to Patient (*If applicable*)

☐ *Parent or guardian of unemancipated minor*
☐ *Court appointed guardian*
☐ *Executor or administrator of decedent's estate*
☐ *Power of attorney*

Authorization for Use and Verbal Disclosure of Protected Health Information

This is not a medical release form for Physicians – there is a different form for that request

I hereby authorize North Dallas Dermatology Associates to use and/or disclose my protected health information as described below to:

Name and relationship to recipient(s) (friends/family only – not physicians):

1._____ Relationship: _____
2._____ Relationship: _____
3._____ Relationship: _____

( ) All Medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.
( ) Only the following type of information: _____
( ) DO NOT disclose any information on file other than to patient.

VALID ONE YEAR FROM DATE SIGNED.

_____ _____

Signature of Patient or Responsible Party *Date*

Consent for treatment of minor child

Please note that you may disregard the notice below if this does not pertain to the patient

I, being the parent or guardian of, _____ in my absence do hereby request and authorize North Dallas Dermatology Associates permission to administer care as necessary. I authorize the following person/persons to authorize medical treatment for my child by North Dallas Dermatology Associates.
I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives. If I choose to terminate the authorization of this form, I understand I must do so in writing. **VALID ONE YEAR FROM DATE SIGNED.**

NAME OF PERSON ACCOMPANYING PATIENT **(Excludes parent/legal guardian)** Relationship to Patient

1._____ _____

2._____ _____

3._____ _____

Parent/Guardian name: _____ *Signature:* _____

Relationship to Child: _____ *Date:* _____

Financial Policy

Thank you for selecting our practice for your dermatological needs. Our goal is to provide you with the highest quality of treatment and service. Your complete understanding of your financial responsibilities is an essential element of your care. If you have any questions about the following policy, please do not hesitate to ask our staff.

Effective January 1st, 2016 all copays, deductibles and co-insurance are due at the time services are rendered. **Please be aware that we collect an estimated payment on a few of these procedures at the time of check out (*please refer to our Procedure Price List* below for details*).** If after submitting an in-network claim, including secondary insurance and you have already met your deductible elsewhere and should your insurance pay any portion of or all charges we will refund your payment upon receipt of your insurance payment.

In the event your health plan determines a service to be "not covered", or if we do not have an authorization on file prior to the appointment or you do not inform us of an insurance change you will be responsible for the complete charge at time services are rendered. We encourage our patients to understand their policy and to contact their insurance provider for clarification of benefits prior to services being rendered.

You may receive a separate bill for laboratory or pathology services from an off-site lab for any tests your physician may order. Please discuss any billing errors or discrepancies with that laboratory.

Please note that you may disregard this notice if you are a Medicare recipient or a self-pay patient.

Procedure Price List	
Biopsy of a skin lesion	$125 for the 1st
Each additional biopsy	$40 each additional
*Destruction of an actinic keratosis/precancerous lesions	$75 - $175
*Destruction of a wart, molluscum, or other benign lesion	$102 - $125
*Excision of a skin lesion	$90 - $385
*Sugical repair of the above listed skin lesion(s)	$185 - $425
*Prices vary depending in size and number of lesion(s)	

Other Miscellaneous Fees	
Cancellation, missed appointments and late arrivals	If we do not receive 24 hour notice there will be a $30.00 cancellation/no show fee billed. Patients with multiple cancellations or missed appointments also may be discharged from our practice. In an event that you are running late, please call our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.
Skin Health SPA*	***Please note** Our cancellation/no show policy differs from our general office policy. Due to the extended appointment times, our charges are based on time allotted for your specific treatment. Please ask for details or see our cosmetic consultant for details.
Returned check fee	There will be a $30.00 charge for all returned checks.
Collection fee	If your account is turned over to our collection agency, you will be responsible for the collection fee charged to us by the agency in addition to your outstanding balance.

Notice to parents with children under age 18 (when applicable):

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for any charges. If a divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

We accept Cash, Checks, MasterCard, Visa, Discover, American Express and Care Credit.

I have read and understand the financial policy, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

_____ _____

Printed Name of Patient *Date*

_____ _____

Signature of Patient or Responsible Party *Date of Birth*

Optional

Credit Card Save on File

For your convenience and as an option, we kindly request that you leave a credit card on file which may be used to reduce your remaining balance after insurance pays. Please complete and sign the following:

Credit Card Authorization

_____ *Initials* I authorize North Dallas Dermatology Associates to bill my insurance for the services rendered today. Upon receipt of payment from my insurance company, I authorize North Dallas Dermatology Associates to charge the below listed credit card in the amount of the remaining unpaid balance.

_____ *Initials* I understand that cosmetic procedures are not billed to my insurance. Should there be a remaining balance on cosmetic services, I authorize North Dallas Dermatology Associates to charge the below listed credit card in the amount of the remaining unpaid balance.

_____ *Initials* An email will be sent to notify me of the additional charge to my credit card.

_____ *Patient Name*

_____ *Patients Date of Birth*

Credit Card Billing Address:

_____ *Address line 1*

_____ *Address line 2*

_____ *City, state, zip code*

_____ *Card holders Email address*

_____ *Best number to be reached*

_____ *Name as it appears on credit card*

_____ *last four numbers on credit card*

_____ *Credit card expiration date*

_____ *Credit card holder authorizing signature*

_____ *Date*

OFFICE USE ONLY:

Employee initials: _____

Date saved/ Sent to PAS: _____