DERMATOLOGY ASSOCIATES of SAN ANTONIO

Patient Information

PATIENT DEMOGRAPHICS **PLEASE PRINT CLEARLY**

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE

SOCIAL SECURITY #	DATE OF BIRTH	SEX	MARITAL STATUS
		☐ MALE ☐ FEMALE	☐SINGLE ☐ MARRIED ☐ SEPERATED ☐ WIDOW

ADDRESS	APT #	CITY	STATE	ZIP

RACE/ETHNICITY (FEDERAL GOVERNMENT GUIDELINES REQUIREMENT)

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐BLACK OR AFRICAN AMERICAN ☐ HISPANIC OR LATINO
☐ WHITE ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ OTHER_____

PRIMARY PHONE # ☐ HOME ☐ CELL ☐ WORK	SECONDARY PHONE # ☐ HOME ☐ CELL ☐ WORK

WHAT IS YOUR PREFERRED METHOD OF APPOINTMENT REMINDER?
☐ TELEPHONE CALL TO PRIMARY NUMBER ☐ TEXT ☐ EMAIL _____

PATIENT'S EMPLOYER	DRIVER'S LICENSE #

☐ YES, I WOULD LIKE TO RECEIVE UPDATES BY EMAIL FROM THIS OFFICE REGARDING COSMETIC PRODUCTS OR SERVICES
EMAIL ADDRESS _____

HOW DID YOU HEAR ABOUT US?

☐ YELLOW PAGES ☐ INSURANCE ☐ OUTSIDE SIGNAGE ☐MAGAZINE ☐ OTHER
☐ REFERRING PHYSICIAN:_____ ☐ FRIEND/FAMILY MEMBER: _____

INSURANCE INFORMATION **PLEASE PRESENT INSURANCE CARD(S) AND PHOTO ID TO THE RECEPTIONIST**

☐ PLEASE CHECK HERE IF YOU ARE SELF-PAY (NO INSURANCE COVERAGE)

PRIMARY INSURANCE CO:		**SECONDARY INSURANCE CO**:	
RESPONSIBLE PARTY		RESPONSIBLE PARTY	
SOCIAL SECURITY #	DATE OF BIRTH	SOCIAL SECURITY #	DATE OF BIRTH
POLICY ID#	GROUP#	POLICY ID#	GROUP#
RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT/GUARDIAN		RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT/GUARDIAN	
EMPLOYER		EMPLOYER	

TERTIARY INSURANCE CO:	RESPONSIBLE PARTY
SOCIAL SECURITY #	DATE OF BIRTH
POLICY ID#	GROUP#
EMPLOYER	RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT/GUARDIAN

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS OR PERSONAL REPRESENTATIVE

☐YES, THE PRACTICE MAY DISCUSS: ☐MEDICAL CONDITION/TREATMENT ☐APPOINTMENTS ☐PRESCRIPTIONS
☐FINANCIAL ☐PATHOLOGY AND/OR LAB RESULTS WITH THE FOLLOWING PERSON(S)
I UNDERSTAND THIS AUTHORIZATION MAYINCLUDE INFORMATION RELATED TO HIV, AIDS, PSYCHIATRIC CARE, TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE OR GENETIC TESTING INIITIAL _____

PLEASE LIST AUTHORIZED PERSON(S) BELOW

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

MEDICAL INFORMATION

PATIENT NAME		DATE OF BIRTH	
PHARMACY NAME	PHONE NUMBER	PRIMARY CARE PHYSICIAN	PHONE NUMBER

ARE YOU ALLERGIC TO ANY MEDICATIONS? □YES □NO
IF YES, LIST MEDICATION AND REACTION BELOW

LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY USING (MAY USE ATTACHMENT)

PERSONAL AND FAMILY MEDICAL HISTORY (SPECIFY FAMILY MEMBER)

SKIN CANCERS	***YES***	***NO***	***SELF***	***FAMILY***		***YES***	***NO***	***SELF***	***FAMILY***
Actinic Keratosis					Gastrointestinal Disease				
Basal Cell Skin Cancer					High Blood Pressure				
Malignant Melanoma					Hyperlipidemia				
Squamous Cell Skin Cancer					Liver Disease				
HIV/AIDS					Lupus				
Hepatitis C					Mental Disorder				
OTHER					Multiple Sclerosis				
Asthma					Psoriasis				
Atrial Fibrillation					Renal Disease				
Blood Clots					Rosacea				
Congestive Heart Failure					Seizure Disorder				
Depression					Taking Blood Thinners				
Diabetes					Thyroid Disease				
Eczema					Tuberculosis				

LIST ANY OTHER HEALTH PROBLEMS

FOR WOMEN, ARE YOU PREGNANT □YES □NO IF YES, HOW MANY WEEKS? _____

TOBACCO USE □ CURRENT □FORMER □NEVER TYPE_____ AMOUNT_____

ALCOHOL USE □ CURRENT □FORMER □NEVER TYPE_____ AMOUNT_____

SURGICAL HISTORY

TYPE_____ DATE _____

TYPE_____ DATE _____

TYPE_____ DATE _____

I WOULD LIKE INFORMATION ON THE FOLLOWING

□ BOTOX	□ SCULPTRA AESTHETIC	□ SKIN TIGHTENING
□ COSMETIC FILLERS	□ BODY CONTOURING/FAT REDUCTION	□ SUN DAMAGE/AGE SPOTS/ REDNESS
□ LASER SKIN RESURFACING	□ SKIN CARE PRODUCTS	□ TATOO REMOVAL
□ SCLEROTHERAPY (SPIDER VEINS)	□ HAIR REMOVAL	□ OTHER _____

CONSENT FOR TREATMENT/MINOR:I hereby consent to treatment and/or services by providers at Dermatology Associates of San Antonio to include examination, treatment, prescribing medication, and skin preparations. If the patient is a minor, and presents to be evaluated and/or treated by a provider at this practice without me or an accompanying parent/legal guardian (after initial visit), I hereby give my permission to evaluate and treat the patient. INIITAL _____

RELEASE OF INFORMATION: I hereby authorize the release of any and all medical information to my insurance carrier(s) or their representative(s), for purposes necessary in the adjudication or processing of any and all insurance claims(s) filed on my behalf and for which I am financially responsible. I also authorize the release of any or all medical information to my primary care or referring physician, to consult if needed, and as necessary to process prescriptions.

ASSIGNMENT OF BENEFITS: I further authorize all insurance benefits be paid to the provider rendering services on behalf of Dermatology Associates of San Antonio, I understand for payment for professional services, including co-payments and deductibles and fees for cosmetic services, are due at time services are rendered. I acknowledge if my managed care plan declines to cover a service for any reason, it becomes the sole obligation of the patient, parents, or guardian to pay in full.

PRIVACY PRACTICES (HIPAA): I acknowledge I have received a copy of Dermatology Associates of San Antonio Notice of Privacy Practices. This document is posted in our front lobby and is available at the front desk.

EMAIL POLICY: Dermatology Associates of San Antonio subscribes itself to the principle of email privacy. Any information submitted will be used only for requested information and internal purposes and will not be sold or revealed to any third parties.

I have read, understood and agreed to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Signature:_____ Date: _____