



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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPERATED <input type="checkbox"/> WIDOW		
ADDRESS		APT #	CITY		STATE	ZIP	
RACE/ETHNICITY (FEDERAL GOVERNMENT GUIDELINES REQUIREMENT)							
<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER <input type="checkbox"/> OTHER _____							
PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK				SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK			
WHAT IS YOUR PREFERRED METHOD OF APPOINTMENT REMINDER? <input type="checkbox"/> TELEPHONE CALL TO PRIMARY NUMBER <input type="checkbox"/> TEXT <input type="checkbox"/> EMAIL _____							
PATIENT'S EMPLOYER				DRIVER'S LICENSE #			
<input type="checkbox"/> 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?							
<input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> INSURANCE <input type="checkbox"/> OUTSIDE SIGNAGE <input type="checkbox"/> MAGAZINE <input type="checkbox"/> OTHER _____ <input type="checkbox"/> REFERRING PHYSICIAN: _____ <input type="checkbox"/> FRIEND/FAMILY MEMBER: _____							
INSURANCE INFORMATION				PLEASE PRESENT INSURANCE CARD(S) AND PHOTO ID TO THE RECEPTIONIST			
<input type="checkbox"/> 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: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT/GUARDIAN				RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT/GUARDIAN			
EMPLOYER				EMPLOYER			
TERTIARY INSURANCE CO:				RESPONSIBLE PARTY			
POLICY ID#				GROUP#			
CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS OR PERSONAL REPRESENTATIVE							
<input type="checkbox"/> YES, THE PRACTICE MAY DISCUSS: <input type="checkbox"/> MEDICAL CONDITION/TREATMENT <input type="checkbox"/> APPOINTMENTS <input type="checkbox"/> PRESCRIPTIONS <input type="checkbox"/> FINANCIAL <input type="checkbox"/> PATHOLOGY AND/OR LAB RESULTS WITH THE FOLLOWING PERSON(S) I UNDERSTAND THIS AUTHORIZATION MAY INCLUDE INFORMATION RELATED TO HIV, AIDS, PSYCHIATRIC CARE, TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE OR GENETIC TESTING INITIAL _____							
PLEASE LIST AUTHORIZED PERSON(S) BELOW							
NAME		RELATIONSHIP			PHONE NUMBER		
NAME		RELATIONSHIP			PHONE NUMBER		

MEDICAL INFORMATION

PATIENT NAME	TELEPHONE NUMBER	DATE OF BIRTH	
PHARMACY NAME	PHARMACY PHONE NUMBER	PRIMARY CARE PHYSICIAN	PCP 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 _____

HAVE YOU HAD A FLU SHOT? YES NO IF SO, WHAT MONTH/DAY? _____ (WE DO NOT OFFER FLU SHOTS , UPDATING RECORDS)

SURGICAL HISTORY

TYPE _____ DATE _____

TYPE _____ DATE _____

TYPE _____ DATE _____

CONSENT FOR TREATMENT: 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.

CONSENT FOR TREATMENT OF A MINOR: If 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.

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: _____