Patient Information

PATIENT DEMOGRAPHICS				PLEASE PRINT CLEARLY	
LAST NAME	FIRST NAME		MID INITIAL	DATE OF BIRTH	RACE/ETHNICITY (FED GOV GUIDELINES REQ)
SOCIAL SECURITY NO.	SEX □ MALE □ FEMALE	MARITAL STATUS	□ YES. I WOULD LIKE TO RECEIVE EMAIL UPDATES REGARDING PRODUCTS AND SERVICES. EMAIL ADDRESS:		
ADDRESS		APT #	CITY	STATE	ZIP
PRIMARY PHONE # □ HOME □ CELL □ WORK		SECONDARY PHONE # □ HOME □ CELL □ WORK		DRIVER'S LICENSE NO.	

HOW DID YOU HEAR ABOUT US?

□ FAMILY/FRIEND □ GOOGLE □ HEALTH FAIR □ HEALTHGRADES □ INSURANCE □ OUTSIDE SIGNS □ OUR WEBSITE
□ SOCIAL MEDIA □ WEDDING FAIR □ YELLOW PAGES □ YELP □ OTHER □ PHYSICIAN REFERRAL:

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#

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS OR PERSONAL REPRESENTATIVE (PLEASE CHECK ALL THAT APPLY)

□ **NO**, DO NOT DISCUSSS □ **YES**, THE PRACTICE MAY DISCUSS: □ MEDICAL CONDITION/TREATMENT □ APPOINTMENTS
□ PRESCRIPTIONS □ 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

PLEASE LIST AUTHORIZED PERSON BELOW

NAME	RELATIONSHIP	PHONE NUMBER

MEDICAL INFORMATION

PHARMACY NAME	PHARMACY PHONE NUMBER	PRIMARY CARE PHYSICIAN	PHONE NUMBER

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

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

PERSONAL AND FAMILY MEDICAL HISTORY (SPECIFY FAMILY MEMBER)

SKIN CANCERS	SELF	FAMILY		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, MAY USE ATTACHMENT OF BACK SIDE.

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

TOBACCO USE □ CURRENT □ FORMER □ NEVER TYPE_____ FREQUENCY_____ AMOUNT_____

ALCOHOL USE □ CURRENT □FORMER □ NEVER TYPE_____ FREQUENCY_____ 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 _____

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.

MEDICAID POLICY: Due to a federal regulation, since we are not Medicaid providers we are not able to treat any patients who are enrolled in any Medicaid plans either as primary or secondary. Patients enrolled in Medicaid cannot waive coverage and pay privately.

Signature:_____ Date: _____