Patient Information

PATIENT DEMOGRAPHICS — **PLEASE PRINT CLEARLY**

LAST NAME	FIRST NAME	M.	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 □ INSURANCE □ OUTSIDE SIGNS □ OUR WEBSITE

□ SOCIAL MEDIA □ 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 VERBAL 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 □ FINANCIAL □ 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

PLEASE LIST AUTHORIZED PERSON BELOW

NAME	RELATIONSHIP	PHONE NUMBER

MEDICAL INFORMATION

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 MEDICAL HISTORY ***(Please mark if yes)***

Skin Cancer		Asthma		Congestive Heart Failure		Multiple Sclerosis			
Skin Rashes		Atrial Fibrillation		Gastrointestinal Disease		Seizure Disorder			
HIV/AIDS		Blood Clots		High Blood Pressure		Thyroid Disease			
Hepatitis C		Diabetes		Kidney Disease		Taking Blood Thinners			
Tuberculosis		Depression		Liver Disease					

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

ALCOHOL USE □ CURRENT □ FORMER □ NEVER

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.

CONSENT OF MEDICATION REQUEST: I hereby give consent to have my medication eligibility and history electronically taken and added to my chart.

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.

NO SHOW POLICY: A $75 fee will be added to your account for any no show or faliure to cancel within 24 hrs and will need to be settled before you can secure any future appointments.

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: _____