BAYTOWN DERMATOLOGY, PA 281-425-9375

Patient Information as of _____ (enter today's date)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

SS# _____-____-_____ Birthdate: _____/_____/_____ Age: _____ Sex ❒ Female ❒ Male

Marital Status □ Single □ Married to: _____ □ Other: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____ Drivers License # (include State) _____

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Is patient is a student: □ Full time or □ Part time □ None **or Retired:** □ Yes □ No

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Race: _____ Ethnicity: _____ Language: _____

Referred by: □ Patient or □ Doctor Name: _____

Heard about us: _____ (internet, newspaper, word of mouth, yellow pages-phone book)

** Authorize release of medical info to: Name: _____ Relationship: _____

❒ Yes ❒ No Is your health insurance through the Affordable Health Care Act Marketplace? A 90 grace period is given to pay your premiums, then the policy is terminated. If this happens, you will be responsible for the bill.

Primary Insurance: _____ Copay $ _____ Referral Required? ❒ No ❒ Yes

Policy # _____ Group # _____ InsPhn# _____

Insured: Name _____ DOB _____ Employer _____

Secondary Insurance: _____ Copay $ _____ Referral Required? ❒ No ❒ Yes

Policy # _____ Group # _____ InsPhn# _____

Insured: Name _____ DOB _____ Employer _____

MEDICARE : I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PRIVATE INSURANCE/SUPPLEMENTAL INSURANCE: I authorize any holder of medical or other information about me to release to the insurance company(s) stated above any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signature _____ **Date** _____

OFFICE POLICIES

Patient Name: _____ DOB: _____

PAYMENT POLICY:

> We accept cash, checks and credit cards (Visa, Mastercard & HSA) as payment.
> All co-pays are paid at the time of service.
> OVERDUE BALANCES are paid prior to seeing the doctor.
> CASH PATIENTS must pay office visit charges prior to seeing the doctor.

CREDIT CARD POLICY:

> New patients are required to leave a credit card on file.
> Patients, who have procedures done, are required to leave a credit card on file.

It is the patient's responsibility to notify the reception desk of at the time of the appointment:

1. New address and phone number information
2. Current insurance coverage

IF YOU DO NOT HAVE A COPY OF YOUR INSURANCE CARD, YOU ARE CONSIDERED A CASH PATIENT. In order to be considered an insurance patient, the patient must have ALL of the following information: Insurance company name, address, phone number, policy number, group number, employer information and policy holder information.

Please do not ask the doctor to "check a spot" on anyone present other than the patient who has an appointment.

BIOPSIES, EXCISIONS AND CRYO-CAUTERY (liquid nitrogen), are considered surgical procedures. If your insurance company has a surgical deductible, these charges will be applied to your deductible.

If a patient has not been seen in three or more years, they are considered a new patient and must fill out paperwork.

Dr. Chan removes skin tags for his existing patients only and out of pocket. Skin tags are not covered by insurance. This is considered a cosmetic procedure.

Dr. Ramón L. Sánchez and Dr. Conner Chan do not accept:

Worker's Compensation • Medicaid • Patients with both Medicare & Medicaid

INSURANCE PATIENTS:

AUTHORIZATIONS/REFERRALS

If you are enrolled in an HMO which requires an authorization/referral from your Primary Care Physician you must have the authorization/referral completed in order to be seen by the physician. If you arrive without the authorization/referral, you have two options:

1. You can reschedule.
2. You can pay for the visit at the time of service, prior to seeing the doctor.

HIPPA: I have received a copy of Baytown Dermatology, PA's Notice of Privacy Practice.

I have read the above and understand my obligations.

_____ _____

Signature of Patient Date signed

Dermatology Medical History

Patient Name: _____ DOB: _____ Date: _____

List all medications you are currently taking (including prescriptions, over-the-counter, vitamins, herbals, birth control):

	Name	Dosage		Name	Dosage
1.			2.		
3.			4.		
5.			6.		

List allergies and level of severity as low, moderate or high and any details:

1. _____ 2. _____
3. _____ 4. _____

	Past Medical History	Details
☐	No Pertinent past medical history	
☐	Under hospice care	
☐	Asthma	
☐	Autoimmune Disorder	
☐	Cancer - Breast	
☐	Cancer - Colon	
☐	Cancer - Lung	
☐	Cancer - other	
☐	Dementia	
☐	Diabetes	
☐	Heart Disease	
☐	Hepatitis	
☐	High blood pressure	
☐	High Cholesterol	
☐	HIV	
☐	Peptic Ulcers	
☐	Pacemaker / Defibrillator	
☐	Radiation Therapy	
☐	Shingles	
☐	Stroke	
☐	Thyroid Disorder	
☐	Tuberculosis	
☐	Pregnant	
☐	Planning future pregnancy	
☐	Lactating	
☐	Other history	

	Skin History	Details
☐	No significant skin history	
☐	Abnormal mole(s)	
☐	Acne	
☐	Actinic Keratosis	
☐	Basal Cell Carcinoma	
☐	Bleed easily	
☐	Develop keoids (scars) after surgery	
☐	Eczema	
☐	Malignant Melanoma	
☐	Other suspicisous lesion	
☐	Problems with healing	
☐	Psoriasis	
☐	Rosacea	
☐	Squamous cell carcinoma	
☐	Urticaria / Hives	
☐	Peptic Ulcers	

History of Cancer

- ☐ None
- ☐ Personal history of skin cancer
- ☐ Personal history of melanoma
- ☐ Family history of skin cancer

Have you ever used a tanning bed?

- ☐ No
- ☐ Yes

Additional Medical History

Patient Name: _____ DOB: _____ Date: _____

	Family History	Details
☐	No contributing Family History	
☐	Adopted	
☐	Autoimmune Disorders	
☐	Malignant Melanoma	
☐	Skin Disease	
☐	Lymphoma/Leukemia	
☐	Other Skin Cancer	
☐	Other Family History	

Surgical History

List surgeries and and date

1. _____ 2. _____

3. _____ 4. _____

Social History:

Have you had or have you been exposed to HIV (AIDS)? ☐ No ☐ Yes

Have you had or have you been exposed to Hepatitis? ☐ No ☐ Yes If yes, type _____

Do you drink alcohol? ☐ No ☐ Yes If YES, _____ drinks per day

Do you use IV drugs? ☐ No ☐ Yes If YES, what? _____ How often? _____

Do you smoke? ☐ No ☐ Yes If YES, how much? _____

Are you currently experiencing:

Constitutional: ☐ none ☐ fatigue ☐ fainting ☐ fever or chills ☐ unexpected weight loss/gain

Immunologic: ☐ none ☐ Seasonal allergies ☐ Asthma ☐ Autoimmune Disease

Skin: ☐ none ☐ itchy skin ☐ dry skin ☐ bleeding ☐ prickly ☐ painful ☐ hot ☐ numb ☐ other

Cardiovascular: ☐ none ☐ blood clots ☐ chest pain ☐ high blood pressure ☐ palpitations

Ear, nose, throat: ☐ none ☐ hearing problems ☐ sore throat ☐ sinus infection ☐ dental issues

Gastrointestinal: ☐ none ☐ abdominal pain ☐ diarrhea ☐ nausea and/or vomiting

Musculoskeletal: ☐ none ☐ joint pain ☐ muscle weakness

Respiratory: ☐ none ☐ shortness of breath ☐ cough ☐wheezing

Genitourinary: ☐ no pain with urination ☐ pain with urination ☐ yeast infection ☐ yeast infection w/antibiotics ☐ no G/U symptoms ☐ menstrual irregularities

Endocrine: ☐ No endocrine symptoms ☐ Pregnant ☐ Thyroid disorder

Other notes: _____

_____ _____

Signed by Patient Date