

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. Any additional charges are paid before end of office visit.

CREDIT CARD POLICY:

- > ALL patients are required to leave a credit card on file.
- > After 3 mailed statements, if no payment and/or arrangement for payment, credit card will be charged.

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

1. New address and phone number information
2. Current insurance coverage
3. If the patient is cash because the office does not accept their insurance, the office will not file non-contracted insurance company. We do not make any attempt to assist. **The patient should see doctors listed as providers for their insurance company.**

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. It is the responsibility of the patient to have this information, not for the office to figure it out.

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 prior to seeing the doctor. 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: _____

Purpose of visit: _____ **How long has it been present:** _____

ALL locations to be treated: _____

Treatments you have used? _____

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

Name	Dosage
1. _____	_____
3. _____	_____
5. _____	_____

Name	Dosage
2. _____	_____
4. _____	_____
6. _____	_____

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

1. _____
3. _____

2. _____
4. _____

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

Skin History	Details
<input type="checkbox"/> No significant skin history	
<input type="checkbox"/> Abnormal mole(s)	
<input type="checkbox"/> Acne	
<input type="checkbox"/> Actinic Keratosis	
<input type="checkbox"/> Basal Cell Carcinoma	
<input type="checkbox"/> Bleed easily	
<input type="checkbox"/> Develop keoids (scars) after surgery	
<input type="checkbox"/> Eczema	
<input type="checkbox"/> Malignant Melanoma	
<input type="checkbox"/> Other suspicious lesion	
<input type="checkbox"/> Problems with healing	
<input type="checkbox"/> Psoriasis	
<input type="checkbox"/> Rosacea	
<input type="checkbox"/> Squamous cell carcinoma	
<input type="checkbox"/> Urticaria / Hives	
<input type="checkbox"/> 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
<input type="checkbox"/> No contributing Family History	
<input type="checkbox"/> Adopted	
<input type="checkbox"/> Autoimmune Disorders	
<input type="checkbox"/> Malignant Melanoma	
<input type="checkbox"/> Skin Disease	
<input type="checkbox"/> Lymphoma/Leukemia	
<input type="checkbox"/> Other Skin Cancer	
<input type="checkbox"/> 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