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.
> After 3 mailed statements, if no payment and/or arrangment for payment, credit card will be charged.

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.

<u>HIPPA:</u> 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		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