Dermatological Association
OF TEXAS

DERMATOLOGICAL ASSOCIATION OF TEXAS

451 N. Texas Ave.
Webster, TX 775988
281-333-3376
Fax: 281-335-4605

1401 Binz St, Suite 200
Houston, TX 77004
713-528-8818
Fax: 713-528-8848

20320 Northwest Fwy. #700
Houston, Texas 77065
713-554-4688
Fax: 832-478-5662

Stephen Tyring, MD, PhD
Lauren Campbell, MD
Karan Sra, MD
Payel Patel, DO

NEW PATIENT FORMS

Welcome to our office. Providing you with exceptional care is the motivation and intention of our physicians and staff.

We appreciate you taking the time to complete these New Patient Forms thoroughly so that we can enter this vital information into your permanent record. This information is critical to us in assisting you with the care, treatment and management of your dermatological conditions.

There are several pages for you to fill out.

The first is a **REGISTRATION FORM** requesting patient and insurance information. Your signature and date at the bottom are required.

Next is a two-page **MEDICAL HISTORY** questionnaire. We must know the details of your current and prior medical condition in order to provide you with quality health care.

Another page details your **FINANCIAL RESPONSIBILITIES** and your rights concerning privacy of your **PROTECTED HEALTH INFORMATION**. Please read these policies and sign and date in both places.

If you are on **MEDICARE** and/or have a **MEDIGAP** policy there is an additional page of statements that you must read and sign.

Finally, we have included a **Consent to Treat** form, just letting you know that some procedures might be applied to your deductible.

If you need assistance completing these forms, our receptionist will be happy to help when you arrive for your appointment.

EMAIL OR FAX COMPLETED FORMS PRIOR TO YOUR APPOINTMENT TO:
Email: registration@dermtexas.com
Fax: Webster 281-335-4605 Museum District 713-528-8848 Cypress 832-478-5662

or bring them with you to your appointment.

Thank you for your cooperation. We look forward to providing exceptional care for you and your skin!

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PATIENT DEMOGRAPHIC INFORMATION

Please **PRINT** clearly and complete **ALL** sections

CLEAR LAKE AREA
451 N. Texas Ave.
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MUSEUM DISTRICT
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CYPRESS
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Houston, Texas 77065
713-554-4688
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PATIENT INFORMATION

Last Name | First Name | Middle Initial | Nickname/Other Name

Home Address: Number & Street Name | Apt./Unit #

City | State | Zip Code

Home Phone | Cell Phone | Work Phone

Date of Birth | Gender ☐ M ☐ F | How did you hear about us? ☐ Physician ☐ Friend Name _____ ☐ Radio ☐ Magazine Which one? _____ ☐ Other _____

INSURANCE INFORMATION

Primary Care Physician | PCP Phone | Referring Physician | Ref. Physician Phone

Do you have health insurance? ☐ Yes ☐ No | Are you the insured or a dependent? ☐ Insured ☐ Dependent

Primary Insurance Company Name | Primary Insurance Address | Phone

Name of Insured: Last Name, First Name and Middle Initial (if patient is dependent) | Insured's Date of Birth

Insured's Address: Street, City, State & Zip (if different from patient) | Insured's Phone Number

Patient's relationship to insured | Name of Primary Parent/Guardian: Last Name, First Name & Middle Initial (if patient is a minor)

Secondary Insurance Company Name | Address | Phone

Name of Insured (if not patient) | Date of Birth | Relationship to patient

MEDICAL INFORMATION PREFERENCES

May we email you medical information or appointment reminders? ☐ Yes ☐ No Email Address: _____

May we leave messages regarding medical information or appointment reminders on your:
home phone? ☐ Yes ☐ No cell phone? ☐ Yes ☐ No work phone? ☐ Yes ☐ No **Brief** **Extended**

Race: ☐ White ☐ Black ☐ Asian ☐ Native American Indian ☐ Other Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Pharmacy Name | Pharmacy Address: Number, Street, City and Zip | Pharmacy Phone

EMERGENCY & CONTACT INFORMATION

In case of emergency, who should we contact: Name | Home Phone | Other Phone | Relationship to patient

Are there other family members or persons with whom you authorize us to discuss your medical information? ☐ Yes ☐ No If yes:

Last Name, First Name, Middle Initial | Phone | Relationship

Last Name, First Name, Middle Initial | Phone | Relationship

SIGNATURE

Patient Signature | Date

I hereby affirm that I am the legal parent or guardian of patient and have authority to make decision regarding medical treatments.

Parent/Guardian: Last Name, First Name, Middle Initial | Parent/Guardian Signature

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PATIENT MEDICAL HISTORY

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Last Name _____ First Name _____

Please describe your skin condition (including location, duration and symptoms):

_____

Is this a new or chronic condition? _____

LIST ALL MEDICAL/HEALTH PROBLEMS (including those for which you are not taking medication):

Condition	Medication

DO YOU HAVE A HISTORY OF THE FOLLOWING:

Skin cancer?	Type: _____ Date: _____
Shingles?	Date: _____
Psoriasis?	
Herpes/cold sores?	

ARE YOU INTERESTED IN RECEIVING INFORMATION REGARDING CLINICAL TRIALS? Yes_____ No_____

DO YOU HAVE DRUG ALLERGIES? □ YES □ NO IF YES, PLEASE SPECIFY TYPE AND REACTION:

Name of medication	Type of allergic reaction

LIST ALL SIGNIFICANT HOSPITALIZATION(S) AND/OR SURGICAL PROCEDURE(S):

Description	Month/Year

FAMILY MEDICAL HISTORY

Mother □ Alive Age ____ □ Deceased Cause of Death _____

Father □ Alive Age ____ □ Deceased Cause of Death _____

Children ____ # Siblings ____

Family history of: □ Skin Cancer □ Other Cancer □ Shingles □ Herpes/Cold Sores

PERSONAL/SOCIAL HABITS AND HISTORY:

Do you use tobacco products? □ No □ Yes Type/Amount_____

Do you drink alcohol? □ No □ Yes # of drinks per week ____

Do you use recreational drugs? □ No □ Yes Type_____

Have you been exposed to HIV? □ No □ Yes

Have you been exposed to Hepatitis? □ No □ Yes

Amount of daily sun exposure? □ Low □ Medium □ High

Do you use sunscreen? □ No □ Yes SPF ___

Do you use tanning beds? □ No □ Yes # of times per month ____

Marital Status □ Single □ Married □ Committed Relationship

Occupation □ Full Time □ Part Time Type of work _____ □ Retired

OTHER MEDICAL INFORMATION

Do you have dry or sensitive skin? □ Yes □ No

Do you have a pacemaker or defibrillator? □ Yes □ No

Do you have a tendency to develop keloids? □ Yes □ No

Are you allergic to tape or bandages? □ Yes □ No

Are you allergic to topical antibiotics? □ Yes □ No

Do you take aspirin or medication to thin your blood? □ Yes □ No

Do you have problems with your immune system? □ Yes □ No

Do you experience excessive sweating? □ Yes □ No

Do you have bleeding problems? □ Yes □ No

Do you have problems with your finger or toe nails? □ Yes □ No

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POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

Prior to seeing a medical professional at DAT, a staff member will discuss with you the likely costs involved in your procedure(s) and review your financial responsibility.

We accept certain insurance plans; therefore please provide us with your insurance card. We will let you know if your plan is one for which we are a designated provider. If you wish to be seen at DAT, you are responsible for payment of all co-pays and or deductible charges at the time of service. If your insurance is a plan for which we are not a designated provider, we are more than willing to provide care and you will be responsible for payment at the time of service.

Please remember that insurance policies may not cover all conditions and fees. To be fully aware of your schedule of benefits, please read your insurance policy or talk with an insurance representative.

Some procedures performed at DAT are considered cosmetic and will not be covered by insurance.
Any laboratory analysis that we require, but do not perform in-house will be sent to an external laboratory as required by your insurance. You may receive a separate bill for laboratory services.

We accept Medicare and will file all claims for patients with Medicare. Please give us your secondary insurance card and we will also file it.

We accept payment in the form of cash, check, credit or debit card. Any checks returned to us due to insufficient funds will result in a fee of $25.00 each.

If you are not going to be able to attend a scheduled appointment, 24 hours advance notice is requested.

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided by DAT, and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

_____ _____

Signature of Patient/Responsible Party Date

HIPAA PRIVACY PRACTICES

As required as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a section concerning Patient Rights under the law. The Notice is available to you at the front desk at your request. You may review the Notice before signing this consent. The patient has the right to restrict the uses of their information.

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your health insurance company and overall health care operations. You have the right to revoke this consent in writing with your signature.

_____ _____

Signature of Patient or Responsible Party Date

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MEDICARE & MEDIGAP PATIENTS

MEDICARE

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Centers of 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. I understand that I can revoke this authorization in writing at any time.

_____ _____

Signature of Patient as it appears on Medicare card Date

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which Medicare automatically "crosses over," we are required to keep a separate signature on file. Please read and sign the statement that follows:

I request authorized Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of Patient as it appears on Medigap card Date

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Treatment Consent Form

Patient Name: _____ DOB:_____

I hereby authorize Dermatological Association of Texas physicians to treat or my dependent.

I understand that any treatment/procedure other than an Office Visit (such as Liquid Nitrogen and biopsy) may not be covered under my co-pay but might be applied to my deductible

Acknowledgement

I certify that I have read and fully understand the contents of this permission for the treatment and I agree to pay any balance that is applied to my deductible.
.

_____ _____
Signature - Patient or Parent/Guardian Date

_____ _____
Signature – Witness Date