Patient Information Form

DERMATOLOGY & LASER CENTER OF SAN ANTONIO

PATIENT INFORMATION

Name (Last, First, MI) :		Today's Date :
Street Address :		
City :	State :	Zip :
Home Phone : Preferred ○	Work Phone : Preferred ○	Cell Phone : Preferred ○
SSN :	Date of Birth :	Gender : M ○ F ○ T ○
Marital Status : single ○ married ○ divorced ○ widowed ○		Race :
Ethnicity :	Preferred Language :	Email Address :

RESPONSIBLE PARTY

Responsible Party/Guarantor (if not patient) :		
Name :		Address City/State/Zip :
Relationship To Patient :		
Home Phone : Preferred ○	Work Phone : Preferred ○	Cell Phone : Preferred ○

EMERGENCY CONTACT

Name :		Relationship To Patient :
Home Phone : Preferred ○	Work Phone : Preferred ○	Cell Phone : Preferred ○

PCP INFO

Primary Care Physician's Name :	Physician Phone :
Physician Address :	

How Did You Find Us ? (e.g. Friend, Family Member, Internet, Physician Referral, etc.)	If Physician Referral, Which Physician :

INSURANCE INFORMATION

PRIMARY INSURANCE

Primary Insurance Company :	Policy #	Group #
Patient's Relationship To Insured : (e.g. Self, Spouse, Child, Other)	Name of Subscriber : (if other than patient)	
Date of Birth of Subscriber :	Address of Subscriber :	

SECONDARY INSURANCE

Primary Insurance Company :	Policy #	Group #
Patient's Relationship To Insured : (e.g. Self, Spouse, Child, Other)	Name of Subscriber : (if other than patient)	
Date of Birth of Subscriber :	Address of Subscriber :	

PHARMACY

Pharmacy Name :	Pharmacy Phone :
Address :	

◯ Yes, the practice may discuss my confidential medical information, treatment, appointments, prescriptions, pathology, and/or lab results with the following person(s) including disclosure by telephone, fax or email.

Name :	Relationship :	Phone :
Name :	Relationship :	Phone :

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation (Irregular Heartbeat)
- ◯ BPH
- ◯ Bone Marrow Transplantation
- ◯ Cancer (other than skin)
- ◯ Hypertension
- ◯ COPD
- ◯ Coronary Artery Disease
- ◯ Depression
- ◯ Diabetes
- ◯ End Stage Renal Disease
- ◯ GERD
- ◯ Hearing Loss
- ◯ Hepatitis
- ◯ Seizures
- ◯ HIV/AIDS
- ◯ Hypercholesterolemia
- ◯ Hyper/Hypothyroidism
- ◯ Leukemia
- ◯ Lung Cancer
- ◯ Lymphoma
- ◯ Prostate Cancer
- ◯ Radiation Treatment
- ◯ Stroke
- ◯ None

◯ Other _____

SURGICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

- ◯ Appendix Removed
- ◯ Bladder Removed
- ◯ Breast: Mastectomy (Right, Left, Bilateral)
- ◯ Breast: Lumpectomy (Right, Left, Bilateral)
- ◯ Breast Biopsy (Right, Left, Bilateral)
- ◯ Breast Reduction
- ◯ Breast Implants
- ◯ Colectomy: Colon Cancer Resection
- ◯ Colectomy: Diverticulitis
- ◯ Colectomy: IBD
- ◯ Gallbladder Removed
- ◯ Heart: Coronary Artery Bypass Surgery
- ◯ Heart: PTCA (proc. For blocked coronary arteries)
- ◯ Heart: Mechanical/Biological Valve Replacement
- ◯ Joint Replacement (within last 2 years)
- ◯ Kidney Removed (Right, Left)
- ◯ Transplant (Kidney, Liver, Heart, Other)
- ◯ Ovaries Removed (Endometriosis, Cyst, Ovarian Cancer)
- ◯ Prostate Removed: Prostate Cancer
- ◯ Prostate Biopsy
- ◯ Prostate: TURP
- ◯ Basal Cell Cancer Surgery
- ◯ Squamous Cell Carcinoma Surgery
- ◯ Melanoma Surgery
- ◯ Skin Biopsy
- ◯ Spleen Removed
- ◯ Hysterectomy
- ◯ None

◯ Other _____

DO YOU HAVE ANY OF THE FOLLOWING SKIN CONDITIONS (PLEASE CHECK ALL THAT APPLY)

- ○ Acne
- ○ Actinic Keratosis
- ○ Basal Cell Skin Cancer
- ○ Blistering Sunburns
- ○ Dry Skin
- ○ Eczema
- ○ Flaking or itchy scalp
- ○ Squamous Cell Skin Cancer
- ○ Hay Fever/Allergies
- ○ Melanoma
- ○ Poison Ivy
- ○ Precancerous Moles
- ○ Psoriasis
- ○ None

Do you have a **family** history of Skin cancer? ○ Yes ○ No
(if yes, please check all that apply)

- ○ Basal Cell Carcinoma
- ○ Squamous Cell Carcinoma
- ○ Melanoma

Which relative(s)? _____

Do you wear sunscreen? ○ Yes ○ No If yes, what SPF _____

Do you tan in a tanning salon? ○ Yes ○ No

SOCIAL HISTORY

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Do you consume alcohol (EtOH or grain alcohol)? _____

- ○ Currently smokes daily
- ○ Currently smokes - not daily
- ○ Has Never smoked
- ○ Has Smoked in the Past

MEDICATIONS (please list all current medications, including vitamins/supplements/herbal remedies and non-prescriptions i.e. aspirin, ibuprofen)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES

Are you allergic to any medications? ○ Yes ○ No

List allergies to medications and type of allergic reaction (example: hives, difficulty breathing, swelling, etc.) None

_____

REVIEW OF SYSTEMS (Please check all that apply regarding your overall health and add any other important information)

- ○ Problems with bleeding
- ○ Problems with healing
- ○ Problems with Scarring (keloid)
- ○ Rash
- ○ Immunosuppression
- ○ Hay Fever
- ○ Chest Pain
- ○ Fever or chills
- ○ Night Sweats
- ○ Unintentional Weight Loss
- ○ Thyroid Problems
- ○ Sore Throat
- ○ Blurry Vision
- ○ Abdominal Pain
- ○ Bloody Stool

- ○ Bloody Urine
- ○ Joint Aches
- ○ Muscle Weakness
- ○ Neck Stiffness
- ○ Headaches
- ○ Seizures
- ○ Cough
- ○ Shortness of Breath
- ○ Wheezing
- ○ Anxiety
- ○ Depression

ALERTS

- ○ Allergy to adhesive
- ○ Allergy to lidocaine
- ○ Allergy to topical antibiotic ointments
- ○ Rapid heartbeat with epinephrine
- ○ Artificial heart valve
- ○ Pregnant or planning pregnancy
- ○ Artificial joins within past 2 years
- ○ Blood thinners
- ○ Defibrilator
- ○ MRSA
- ○ Pacemaker

Do you have any other medical history that you would like us to be aware of ?

_____

_____

_____

Name _____ **Date** _____

NOTICE ON PRIVACY PRACTICES (HIPAA NOTICE)

INTRODUCTION

At The Dermatology & Laser Center of San Antonio™, we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORDS/HEALTH INFORMATION

Each time you visit The Dermatology & Laser Center of San Antonio™, a record of your visit is made, referred to as your health or medical record... Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data and serves as a:

- Basis for planning your care and treatment
- VitiligoMeans of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use of and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

The Dermatology & Laser Center of San Antonio™ is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communications of health information via alternative means and/or locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment

Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations

Your health information may be used as necessary to support the day-to-day activities and management of The Dermatology & Laser Center of San Antonio™, for example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates

In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family

Due to the nature of our field, we will use our best judgement when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research/Teaching/Training

We may use your information for the purposes of determining if you are eligible for one of our research studies. We may also use your information for the purposes of teaching and training.

Healthcare Oversight

Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law.

Law Enforcement

Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment Reminders

The practice may use your information to remind you about upcoming appointments. Typically, appointments reminders are sent by email, text message, or a brief non-specific message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods, please inform the practice.

Other uses and disclosures

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

For More Information or to Report a Problem

If you have complaints, questions, or would like additional information regarding this notice or the privacy practices of The Dermatology & Laser Center of San Antonio™, please contact:

Steven. A. Davis, M.D.
Dermatology & Laser Center of San Antonio™
7810 Louis Pasteur Dr. STE 200
(210) 614-3355

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board Attention:
Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353
For more information please visit our website at www.tmb.state.tx.us

AVISO SOBRE LAS QUEJAS
Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas:

Texas Medical Board Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353 Para obtener más información, visite nuestro sitio web en www.tmb.state.tx.us

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office of Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.D., 20201

CONSENT FOR TREATMENT

I hereby consent to treatment and/or services, by providers at the Dermatology & Laser Center of San Antonio™ to include examination, treatment, prescribing medication and skin preparations. If the patient is a minor nd presents to be evaluated and/or treatment by a provider at this practice without me or an accompanying parent/legal guardian **(after the initial visit)** I hereby give my permission to evaluate and treat the minor patient.

RELEASE OF INFORMATION

I hereby authorize the release of any & all information to my insurance carrier(s) or their representative, for purposes necessary in the adjudication or processing of any & all insurance claim(s) filed on my behalf & 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 consultants 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 the Dermatology & Laser Center of San Antonio™. I understand that payment for professional services, including copayments and deductibles and fees for cosmetic ~~services are~~ due at the time services are rendered. I acknowledge that if my managed care plan declines to cover service for any reason, it becomes the sole obligation of the patient, parent or guardian to pay in full.

Initial _____

PRIVACY PRACTICES (HIPAA) AND OFFICE POLICIES

I acknowledge that I have received a copy of the Dermatology & Laser Center of San Antonio's™ **Notice of Privacy Practices** and **Office Policies.** These documents are always available at the front desk.

PATHOLOGY & LAB FEES

Anytime a growth is removed from the skin, the tissue will be automatically sent for pathology. Our office uses an outside pathologist and/or lab for these services. You will receive a separate bill from the pathologist or lab for any services they render.

Initial _____

EMAIL POLICY

The Dermatology & Laser Center of San Antonio™ subscribes itself to the principles 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.

I have reviewed, understood, and agree to the forgoing. The information which I have provided is true and complete the best of my knowledge.

Patient or Authorized Signature	Relationship to Patient	Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

By signing this form, I am confirming that I have been informed of my rights to privacy regarding my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly
- Process insurance claims, insurance applications, and prescriptions.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I have been given the right to review and receive a copy of such notice. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used. I also understand that you are not required to agree to my requested restriction(s), but if you do agree then you are bound to abide by such restriction(s). If I do not sign this consent, The Dermatology & Laser Center of San Antonio™ may decline to provide treatment to me.

I have read and consent to the above information

Patient or Authorized Signature	Relationship to Patient	Date