DERMATOLOGY ASSOCIATES OF UPTOWN

DERMATOLOGY CONSULTANTS OF NORTH DALLAS

Patient Information (Please Print) Appt. Date ____/____/____

Last name: _____ First:_____ MI:___ DOB:_____
Address:_____ Apt:_____
City:_____ State:_____ Zip:_____ Phone:_____
E-mail address: _____ Cell:_____
SS#:_____ Marital Status:_____ Gender: M or F

Responsible Party (If Different From Patient):
Last name: _____ First:_____ MI:___ DOB:_____
Address:_____ Apt:_____
City:_____ State:_____ Zip:_____ Phone:_____
SS#:_____ Marital Status:_____ Gender: M or F

Insurance Information (Please present insurance card at time of check in)

Primary Insurance Name:_____
Name of Insured:_____
DOB of Insured _____
Policy #:_____
Group #:_____
Relationship to patient:_____

Secondary Insurance:_____
Name of Insured:_____
DOB of Insured _____
Policy #:_____
Group #:_____
Relationship to patient:_____

In case of emergency, who should be notified:Name/Phone:_____
Referred By:_____
Primary Care Physician Name/Phone:_____

I authorize the release of medical information to my primary care or referring physicians and consultants if needed and as necessary to process insurance claims, insurance applications and perscriptions. I also authorize payment of medical benefits to the physician.

_____ _____
Patient or Responsible Party Signature Date

Copays, coinsurance and deductibles are due at the time services are rendered. If you have a procedure in the office, (such as a biopsy, treatment of warts, surgery, etc.), you may be subject to deductible and coinsurance, which is not the same as your copay. Patients are responsible for verifying insurance coverages and obtaining a referral from their primary care doctor.

I have read and agree to this policy.

_____ ____/____/____
Signature Date

History and Intake Form

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Today's Date _____

Patient's Name _____Date of Birth _____

Patient's phone # _____

Preferred Pharmacy: _____ Street Name: _____

Pharmacy Phone#: _____ Pharmacy City or Zip code:_____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst

Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Other _____

Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma?Yes No
If yes, which relative(s)? _____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Currently Smokes
Has smoked in the past
Never smoked
Former smoker

Alcohol Use:
None
less than 1 drink per day
1-2 drinks per day
3 of more drinks per day

Other_____

Family History (Only first degree relatives)

_____

_____

_____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

problems with bleeding	yes	no	abdominal pain	yes	no
problems with healing	yes	no	bloody stool	yes	no
problems with scarring	yes	no	bloody urine	yes	no
rash	yes	no	joint aches	yes	no
****Isotretinoin****	yes	no	muscle weakness	yes	no
Chills	yes	no	neck stiffness	yes	no
Immunosuppression	yes	no	headaches	yes	no
hay fever	yes	no	seizures	yes	no
chest pain	yes	no	cough	yes	no
fever or chills	yes	no	shortness of breath	yes	no
night sweats	yes	no	wheezing	yes	no
unintentional weight loss	yes	no	anxiety	yes	no
thyroid problems	yes	no			
sore throat	yes	no	depression	yes	no
blurry vision	yes	no			

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?

Date of your last flu shot _____

Date of your last pneumonia shot _____

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Limitations on the information you may release subject to this Release Form are as follows:

_____
_____
_____

Release my protected health information to the following person(s)/entity: (Spouse, Relative or PCP)

Name:_____
Street:_____
City:_____ State:_____ Zip:_____

The reasons or purposes for this release of information are as follows:

_____
_____
_____

Patient signature (or parent, guardian or legal representative):

_____

Date:_____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

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Kent Aftergut, MD and Molly Austin, MD

PATIENT CONSENT

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) has disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Facility with affiliation and remuneration: ADG Pathology

If you have any questions, please do not hesitate to ask.

_____	_____	_____
Signature of Patient or Responsible Party	Patient Name (print)	Date
_____	_____	_____
Signature of Co-Responsible Party	Your Name (print)	Date

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PATIENT HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment payment, or healthcare operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

*Protected health information may be disclosed or used for treatment, payment or health care operations

*The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice *The Practice has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions

*The patient may revoke this Consent in writing at any time and all future disclosures will then cease

*The Practice may condition receipt of treatment upon the execution of this Consent.

PRACTICE POLICIES:

In order to serve your needs better, we ask that you read our policies and sign below.

1. We request 24 hour cancellation notice. Failure to call, "no shows," will be charged a $25 administrative fee that is not billable to insurance. Surgery "no shows" will be charged $75.
2. Prescription refills may take 24-48 hours to be processed. Please call your pharmacy to request refills.
3. Our office strives not to over-schedule or make patients wait, but this is a doctor's office and we cannot always guarantee you will be seen on time. If the waiting time approaches an hour, we will attempt to notify out patients and offer to reschedule.
4. If a patient loses their lab requisition form, there will be a $5 administration fee.
5. Copays and deductibles are due at the time services are rendered.
6. Patients are responsible for verifying insurance coverage and obtaining a referral from their PCP.
7. We attempt to make courtesy phone calls to remind you of your appointment but are unable to provide this service at all times. If you do not receive a reminder phone call and forget to come to your appointment, this does not cancel our "no show" policy above.
8. All returned checks will be charged $25 administrative fee.
9. Reissued Refund checks will incur a $25 administrative fee.

This Consent was signed by: _____ _____

Printed Name-Patient or Representative Relationship to patient (if other than pt)

_____ ____/____/____

Signature Date

Witness: _____ _____ ____/____/____

Printed Name-Practice Representative Signature Date