

**REGISTRATION INFORMATION**

Name \_\_\_\_\_ Date \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_  
Street City State Zip

Email: \_\_\_\_\_ @ \_\_\_\_\_ SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_

**Phone:**

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Preferred contact method: Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Email: \_\_\_\_\_

Gender:  M  F Occupation \_\_\_\_\_

Race:  White  Black/African American  Asian  American Indian or Native Alaskan  
 Native Hawaiian/Pacific Islander  Other \_\_\_\_\_

Ethnicity:  Non-Hispanic/Latino  Hispanic/Latino Language:  English  Spanish  Other \_\_\_\_\_

Referring physician \_\_\_\_\_ Primary care physician \_\_\_\_\_

**Financial Responsible Party (If different from patient):**

Name \_\_\_\_\_ DOB: \_\_\_\_\_  
First MI Last

SSN#: \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Relationship to patient \_\_\_\_\_

**Emergency Contact Information:**

In case of emergency, whom should we notify? \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

**HIPAA CONSENT - Patient Record of Disclosures**

I wish to be contacted in the following manner (check all that apply):

\_\_\_ Home Telephone \_\_\_\_\_  
\_\_\_ OK to leave a message with details \_\_\_ Leave message with call-back number only

\_\_\_ Work Telephone \_\_\_\_\_  
\_\_\_ OK to leave a message with details \_\_\_ Leave message with call-back number only

\_\_\_ Cell Telephone \_\_\_\_\_  
\_\_\_ OK to leave a message with details \_\_\_ Leave message with call-back number only

**If our office is unable to communicate by phone, then Written Communication can be sent to:**

\_\_\_ home address \_\_\_ work/office address

\_\_\_ In my absence, I give authorization for Friendswood Dermatology to leave a message with

\_\_\_\_\_  
(Name) (Relationship to patient)  
for matters regarding: \_\_\_my appointment reminders \_\_\_my account such as billing and amount due  
\_\_\_my treatment/test results

\_\_\_ If my family member calls the office, I give authorization for Friendswood Dermatology to discuss my medical

information with \_\_\_\_\_  
(Name) (Relationship to patient)

**I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.**

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Birth date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record

**Note: Uses and disclosures for Treatment Records, Payment Information and Healthcare Operations may be permitted without prior consent in an emergency.**

**Record of Disclosures of Protected Health Information  
(This section below is to be completed by Office Staff only when disclosing records)**

Date	Disclosed to Whom Address or Fax No	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure is authorized
- (2) Type Key: T= Treatments, P= Payment Information; O= Healthcare Operations
- (3) Enter how disclosure was made: F= fax; P= Phone; E= Email; M= Mail; O= Other

\*see Records of PHI Disclosures in EHR

# Financial Policy

Thank you for choosing Friendswood Dermatology as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our personal professional relationship, it is important that you have an understanding of our financial policy.

**All patients must read and sign this form prior to receiving services.**

- **We may Charge you “No Show” fee \$35 (\$100 for Surgery or Laser) appointment if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.**
- It is your responsibility to provide us with your most current insurance information.
- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for the services rendered.
- We must emphasize that, as medical providers, our relationship with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/ or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However you are responsible for paying the full amount determined by your insurance company once they have paid your claim- regardless of our estimation.
- **It is your responsibility to provide us with your most current billing information.**
- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us and with the updated information
- We will send a statement (to the billing address you provide) notifying you if any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (281) 482-3376.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due account may be subject to a \$5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney’s fees and court cost if applicable.
- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agrees upon your account may be referred to a professional collection agency and/ or attorney. You will be responsible to pay all collection costs incurred, including attorney’s fees and court cost if applicable.
- If your account is assigned to a collection agency you will be notified by certified mail that you will no longer be able to receive services from Friendswood Dermatology Cosmetic & Skin Cancer Center, PLLC. Failure to accept this certified letter (and /or to pick it up at the post office) serves a notice of termination of services.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$35 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

**I UNDERSTAND AND AM WILLING TO COMPLY WITH THE ABOVE POLICIES.**

\_\_\_\_\_  
Signature Patient/Responsible Party

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Past Medical History:** (Select any of the following medical conditions that you currently have)

- |  |   |
|--|---|
| <input type="checkbox"/> <b>None</b>                               | <input type="checkbox"/> H/O: hypertension                      |
| <input type="checkbox"/> Anxiety disorder                          | <input type="checkbox"/> Hearing loss                           |
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> HIV/AIDS                               |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Hypercholesterolemia                   |
| <input type="checkbox"/> Atrial fibrillation (Irregular Heartbeat) | <input type="checkbox"/> Hyperthyroidism                        |
| <input type="checkbox"/> BPH (Benign Prostatic Hyperplasia)        | <input type="checkbox"/> Hypothyroidism                         |
| <input type="checkbox"/> Cerebrovascular accident                  | <input type="checkbox"/> Inflammatory disease of liver          |
| <input type="checkbox"/> Chronic obstructive lung disease          | <input type="checkbox"/> Leukemia                               |
| <input type="checkbox"/> Coronary arteriosclerosis                 | <input type="checkbox"/> Malignant lymphoma                     |
| <input type="checkbox"/> Depressive Disorder                       | <input type="checkbox"/> Malignant tumour of lung               |
| <input type="checkbox"/> Diabetes mellitus                         | <input type="checkbox"/> Malignant tumour of breast             |
| <input type="checkbox"/> Disease caused by 2019-nCoV               | <input type="checkbox"/> Malignant tumour of colon              |
| <input type="checkbox"/> Elevated blood pressure                   | <input type="checkbox"/> Malignant tumour of prostate           |
| <input type="checkbox"/> End Stage Renal Disease                   | <input type="checkbox"/> Radiation therapy treatment management |
| <input type="checkbox"/> Epilepsy                                  | <input type="checkbox"/> Transplantation of bone marrow         |
| <input type="checkbox"/> Gastroesophageal reflux disease           | <input type="checkbox"/> Other _____                            |

**Past Surgeries:** (Have you had any surgeries on the following organs?)

- |  |   |
|--|---|
| <input type="checkbox"/> <b>None</b>   | <input type="checkbox"/> Lumpectomy of left breast  |
| <input type="checkbox"/> Abdominoperineal resection                                | <input type="checkbox"/> Lumpectomy of right breast   |
| <input type="checkbox"/> Bilateral replacement of knee joints                      | <input type="checkbox"/> Mastectomy of left breast  |
| <input type="checkbox"/> Biopsy of breast  | <input type="checkbox"/> Mastectomy of right breast   |
| <input type="checkbox"/> Biopsy of prostate  | <input type="checkbox"/> Mechanical heart valve replacement                                   |
| <input type="checkbox"/> Coronary artery bypass graft                              | <input type="checkbox"/> Oophorectomy   |
| <input type="checkbox"/> Entire transplanted kidney                                | <input type="checkbox"/> Pancreatectomy   |
| <input type="checkbox"/> Excision of basal cell carcinoma                          | <input type="checkbox"/> Percutaneous extraction of kidney stone with fragmentation procedure |
| <input type="checkbox"/> Excision of melanoma                                      | <input type="checkbox"/> Portosystemic shunt operation  |
| <input type="checkbox"/> Excision of squamous cell carcinoma                       | <input type="checkbox"/> Prostatectomy  |
| <input type="checkbox"/> H/O: colostomy  | <input type="checkbox"/> Prosthetic arthroplasty of bilateral hips                            |
| <input type="checkbox"/> H/O: tubal ligation                                       | <input type="checkbox"/> Splenectomy  |
| <input type="checkbox"/> History of appendectomy                                   | <input type="checkbox"/> Surgical biopsy of skin  |
| <input type="checkbox"/> History of bilateral mastectomy                           | <input type="checkbox"/> Total nephrectomy  |
| <input type="checkbox"/> History of cholecystectomy                                | <input type="checkbox"/> Total orchidectomy   |
| <input type="checkbox"/> History of colectomy                                      | <input type="checkbox"/> Total replacement of left hip joint                                  |
| <input type="checkbox"/> History of liver excision                                 | <input type="checkbox"/> Total replacement of left knee joint                                 |
| <input type="checkbox"/> History of percutaneous transluminal coronary angioplasty | <input type="checkbox"/> Total replacement of right hip joint                                 |
| <input type="checkbox"/> History of tissue graft heart valve replacement           | <input type="checkbox"/> Total replacement of right knee joint                                |
| <input type="checkbox"/> History of total cystectomy                               | <input type="checkbox"/> Skin: Squamous Cell Carcinoma  |
| <input type="checkbox"/> Lumpectomy of breast                                      | <input type="checkbox"/> Transplantation of heart   |
| <input type="checkbox"/> History of transurethral prostatectomy                    | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Hysterectomy  |   |
| <input type="checkbox"/> Kidney biopsy   |   |
| <input type="checkbox"/> Low anterior resection of rectum                          |   |
| <input type="checkbox"/> Transplantation of liver                                  |   |

**History and Intake Form**

**Skin Disease History:** (Have you had any of the following skin conditions)

- None
- Acne
- Actinic keratosis
- Asteatosis cutis
- Basal Cell Skin Cancer
- Contact dermatitis due to poison ivy
- Dysplastic nevus of skin
- Eczema
- Other \_\_\_\_\_
- H/O: asthma
- H/O: hay fever
- Malignant melanoma
- Pruritus of scalp
- Psoriasis
- Squamous cell carcinoma
- Sunburn of second degree

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)  None

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**Drug Allergies:** \_\_\_\_\_  No Known Drug Allergies

**Social History**

Smoking Status:

- Current every day smoker
- Former smoker
- Never smoker

Alcohol Use:

- None
- Less than 1 drink per day
- 3 or more drinks per day

**Family History**

Family history: \_\_\_\_\_

**Pharmacy:**

- CVS  HEB  Kroger  K-Mart  Sam's  Target  Walgreens  Wal-Mart
- Other \_\_\_\_\_

Location: \_\_\_\_\_

**Describe in the space below your main dermatologic symptoms/problems, how long you have had them, and past treatment(s):**

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**Review of Systems:**

- Yes  No Problems with bleeding
- Yes  No Problems with healing
- Yes  No Problems with scarring (hypertrophic or keloid)
- Yes  No Rash
- Yes  No Fever or Chills
- Yes  No Chest pain
- Yes  No Wheezing
- Yes  No Shortness of breath
- Yes  No Blurry vision
- Yes  No Hay fever
- Yes  No Sore throat
- Yes  No Cough
- Yes  No Night sweats
- Yes  No Unintentional weight loss
- Yes  No Joint aches
- Yes  No Muscle weakness
- Yes  No Artificial joints with past 2 years
- Yes  No Neck stiffness
- Yes  No Headaches
- Yes  No Abdominal pain
- Yes  No Bloody stool
- Yes  No Bloody urine
- Yes  No Pregnancy or planning a pregnancy
- Yes  No Nursing/Lactation/Breastfeeding
- Yes  No Latex allergy
- Yes  No Adhesive/tape allergy
- Yes  No Lidocaine allergy
- Yes  No Epinephrine causes rapid heartbeat
- Yes  No Defibrillator
- Yes  No Pacemaker
- Yes  No Other implanted electrical stimulatory device
- Yes  No Need to take antibiotic prior to procedures
- Yes  No Artificial heart valve
- Yes  No MRSA history
- Yes  No Blood thinners (Warfarin/Coumadin, Heparin, Lovenox, etc.)
- Yes  No Immunosuppression
- Yes  No HIV or AIDS
- Yes  No Hep B or Hep C

**Cosmetic Consultation Questionnaire**

Which treatments interest you: (please check all that apply)

- Botox    Filler    Chemical Peels    Laser    Sclerotherapy (Spider Veins)    Not Sure

What are your cosmetic concerns: (please check all that apply)

- Brown spots    Breakouts    Skin Discoloration    Skin Texture    Fine Lines/Wrinkles  
 Skin Care    Other \_\_\_\_\_

Are you currently using any of the following products: (please check all that apply)

- Retin-A/Tretinoin                       Valtrex/Zovirax/Acyclovir/Famvir                       Coumadin/Warfarin  
 Hormone Replacement                       Birth Control Pills     Plavix  
 Aspirin     Heparin  
 Accutane (within the past 1 year)  
 Glycolic Acid/Alpha-hydroxy Acid

Vitamins: \_\_\_\_\_

Antibiotics: \_\_\_\_\_

Skin Lightening: \_\_\_\_\_

Acne Medications: \_\_\_\_\_

FRIENDSWOOD DERMATOLOGY \*\*CONFIDENTIAL\*\*



***Friendswood Dermatology, Cosmetic, & Skin Cancer Center***  
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