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 and 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)

- ☐ **None**
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

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

- ☐ **None**
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Mastectomy (Both Breast)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammed Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Both)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Right)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other_____

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

- ☐**None**
- ☐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
- ☐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) ☐**None**

_____

_____

_____

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):

_____

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 Immunosuppression
☐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 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:_____

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