BELLAIRE DERMATOLOGY

6565 West Loop South #800 | Bellaire, TX 77401 | P: 713.661.4383 | F: 713.661.4346

# Patient Registration Form

Please provide the following information if you are a new patient, your information has changed since your last visit, or if it has been 12 months or longer since your last visit. Thank you for your time and cooperation.

Last Name First Name Middle Initial

Street Address City State Zip Code

Social Security Number Date of Birth

Marital Status:
Single ☐
Married ☐
Other ☐

Home Phone Number Cell Phone Number Work Phone Number

Email Address **Referred by**

Gender (select one): ☐ M ☐ F

Preferred Language (select one): ☐ English ☐ Spanish ☐ Other _____

Ethnicity (select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (select one): ☐ Not Disclosed ☐ White ☐ Black or African American ☐ Asian ☐ American Indian/Multi-Racial

***I understand that by signing this form, I certify that all information provided is accurate to the best of my knowledge. I have been provided a copy of the HIPAA Privacy Practices and have read and understood the policy. I have also been provided a copy of the Financial Policy Practices and agree to the terms.***

***I understand that my contact information will not be shared with any other third parties for solicitations, but that I will receive reminders about upcoming appointments.***

**Patient or Guarantor's Signature** **Date**

**Patient Name: _____ Account #_____**

## PRACTICE FINANCIAL POLICY

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding payment guidelines, our staff is trained to consistently inform you of the financial policies of our office.

**PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN.** We will be more than happy to provide that care within the guidelines of your contract with your insurance company; however, it is your responsibility to understand your benefits and to call your insurance company for clarification of questions relating to your coverage. Payment for non-covered charges and balances not paid by your insurance company is ultimately your responsibility.

**Please read and initial each policy below:**

As a courtesy, we will obtain in-office benefits for patients with whom our providers are Preferred Providers (contracted health plans). Once these benefits have been determined, payment of any co-pays, annual deductibles, co-insurances and/or non-covered or cosmetic procedures is required at the time services are rendered. _____ Initials

HMO patients and some managed care patients are responsible for obtaining the necessary referrals prior to their appointment. Please call your insurance company to determine if a referral is required from your Primary Care Physician. Appointments may be rescheduled if our office does not receive the required referral by the time of your visit. In addition, unauthorized (referrals not obtained) and non-covered services are the patient's responsibility and full payment for these services are expected at the time of visit. _____ Initials

Patients with health insurance with whom our providers are not contracted with are expected to pay for the full charges at the time of the visit. An Attending Physicians' Statement will be provided to you to submit to your insurance company for reimbursement. We do not file insurance claims for non-contracted health plans. This includes non-contracted secondary plans as well. _____ Initials

If a small sample of growth on your skin is removed, your sample may be sent to our dermapathologist, Dr. Howard Gerber, or an independent pathologist, who examines the sample under a microscope and determines the type of growth or disease present. This helps your provider determine the best possible treatment for you. Thus, there may be a pathology charge for preparation and evaluation of the tissue sample, in addition to your provider's charge for removal of the tissue. _____ Initials

Patients requesting an appointment for cosmetic, vein, surgery or laser appointments will be required to put a credit card on file or pay a $150 deposit when making an appointment. This deposit will be applied to the total treatment cost and is non-refundable should the patient fail to cancel their appointment 24 hours in advance of the scheduled appointment or does not show for the appointment. _____ Initials

There will be a $50.00 charge for missed medical appointments or medical appointments not canceled within 24 hours of appointment time. _____ Initials

There will be a $35.00 surcharge for all checks written and returned by the bank due to insufficient funds. _____ Initials

With your cooperation, you should be able to receive all the benefits offered to you by your insurance plan, allowing us to do what we do best – concentrating on your dermatological needs.

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

_____ _____

**Patient Signature** **Date**

## TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient Name: _____ DOB: _____Account: _____

I understand that as part of my health care, Bellaire Dermatology Associates (BDA), creates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A tool to notify me of various events, clinical studies, and ongoing opportunities for medical care related to my medical history
- A basis for planning my care & treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis, medical and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and the competence of healthcare professionals.

I hereby consent to the clinic's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the clinic. In addition, I acknowledge that I received, on the date indicated below, a copy of the clinic's ***Notice of Privacy Practices***, which describes the obligations of the clinic regarding its use and disclosure of my individually identifiable health information and my rights regarding this information.

Bellaire Dermatology Associates is authorized by this form to disclose and/or discuss my protected health information with the following named people (identified by relationship, date of birth, and phone number):

Name: _____ DOB: _____ Phone: _____
Relationship to Patient: ☐Spouse ☐ Child ☐Parent ☐Other

Name: _____ DOB: _____ Phone: _____
Relationship to Patient: ☐Spouse ☐ Child ☐Parent ☐Other

I understand that I have the right to revoke anyone listed above on this authorization by completing a new copy of this form. All revocations must be sent to the clinic address to the attention of the ***Privacy Officer, Bellaire Dermatology Associates, 6565 West Loop South, Suite 800, Bellaire, Texas, 77401,*** and are not effective until received by such. _____(initial)

**Photographic Release**

I, the undersigned, hereby give Bellaire Dermatology Associates and its clients or agents permission to use the photographs that they have taken of me.

1. To copyright in their name or any other name that they may choose.
2. To use and publish the same in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose including art, illustration, promotion, advertising, or trade.
3. It is understood that the use of the photographs is for illustrating the medical procedure and demonstration of treatment outcomes.

I hereby release Bellaire Dermatology Associates and its agents from any and all claims and demands arising out of, or in conjunctions with, the use of the photographs. _____(initial)

**Communication Release**

By checking one of the boxes below, I authorize Bellaire Dermatology Associates to leave a voice mail message concerning biopsies, tests or lab results in the event they are unable to contact me directly via telephone.

☐ MAY leave voice mail message ☐ MAY NOT leave voice mail message

By checking one of the boxes below, I authorize Bellaire Dermatology Associates to communicate with me via unsecured email or the patient portal concerning biopsies, tests or lab results in the event they are unable to contact me directly via telephone.

☐ MAY send unsecured email messages ☐ MAY NOT send unsecured email messages

_____ _____
***Signature*** ***Date***

_____ _____
***Responsible Party & Relationship to Patient*** ***Date***

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NAME: _____ OCCUPATION: _____ PREFERRED NAME: _____
AGE: _____
REFERRED BY: _____ HOBBIES: _____

**GENERAL MEDICAL HISTORY:** Do you have or have you ever had any of the following?

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ANXIETY/DEPRESSION | ☐ | ☐ | GERD | ☐ | ☐ | PACEMAKER/DEFIB |
| ☐ | ☐ | ARTHRITIS | ☐ | ☐ | HEARING LOSS | ☐ | ☐ | RADIATION TREATMENT |
| ☐ | ☐ | ASTHMA | ☐ | ☐ | HEPATITIS A B C | ☐ | ☐ | SEIZURES |
| ☐ | ☐ | ATRIAL FIBRILLATION | ☐ | ☐ | HEART DISEASE/ARRYTHEMIA | ☐ | ☐ | STROKE |
| ☐ | ☐ | ANEMIA | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | THYROID DISEASE |
| ☐ | ☐ | AUTOIMMUNE COND TYPE_____ | ☐ | ☐ | HIGH CHOLESTEROL | OTHER:_____ | | |
| ☐ | ☐ | BONE MARROW/ORGAN TRANS | ☐ | ☐ | HIGH BLOOD PRESSURE | _____ | | |
| ☐ | ☐ | CANCER/TYPE_____ | ☐ | ☐ | KIDNEY DISEASE | | | |
| ☐ | ☐ | COPD/EMPHYSEMA | ☐ | ☐ | LUPUS | _____ | | |
| ☐ | ☐ | DIABETES | ☐ | ☐ | MIGRAINES | | | |

**SURGERIES:**

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | APPENDIX | ☐ | ☐ | HYSTERECTOMY/TUBAL LIGATION | ☐ | ☐ | SPLEEN |
| ☐ | ☐ | BLADDER | ☐ | ☐ | JOINT REPLACEMENT TYPE_____ | ☐ | ☐ | TRANSPLANT SURGERY |
| ☐ | ☐ | BREAST RECONS: R L B | ☐ | ☐ | MASECTOMY/LUMPECTOMY R L B | ☐ | ☐ | VALVE REPLACEMENT |
| ☐ | ☐ | DENTAL IN LAST 6 MONTHS | ☐ | ☐ | MELANOMA | OTHER:_____ | | |
| ☐ | ☐ | GALLBLADDER | ☐ | ☐ | PROSTATE | | | |
| ☐ | ☐ | HEART SURGERY/STENT | ☐ | ☐ | PROSTATE BIOPSY/CANCER | _____ | | |
| | | | | | | _____ | | |

**SKIN TYPE:**

If exposed to the sun in the summer without sunscreen, would you: 1. always burn, never tan; 2. always burn, sometimes tan; 3. sometimes burn, always tan gradually; 4. burn minimally, always tan well; 5. rarely burn, tan profusely; 6. never burn, deeply pigmented.

| | | | | | |
|---|---|---|---|---|---|
| ☐ ☐ | ACNE | ☐ ☐ | ECZEMA | ☐ ☐ | KELOID |
| ☐ ☐ | ACTINIC KERATOSIS | ☐ ☐ | FLAKING OR ITCHY SKIN | ☐ ☐ | **MELANOMA** |
| ☐ ☐ | BASAL CELL CANCER/SCC | ☐ ☐ | HAY FEVER/ALLERGIES | ☐ ☐ | PRECANCEROUS MOLES |
| ☐ ☐ | BLISTERING SUNBURNS | ☐ ☐ | HSV | ☐ ☐ | PSORIASIS |

OTHER:_____

SKIN CANCER LOCATION: _____ TYPE: _____ TREATED BY: _____
Do you wear sunscreen? ☐/☐ If yes, what SPF? _____
Did you tan in tanning salons? ☐/☐

**FAMILY HISTORY:** Select any conditions affecting a blood relative and specify who is affected below.
Melanoma ☐ Basal cell or squamous cell skin cancer ☐ Psoriasis ☐ Eczema ☐ Hay fever / allergies ☐ Asthma ☐ Acne ☐
Which relative(s)?
_____
Any other family history?
_____
Are you pregnant or breastfeeding? ☐/☐ If no, method of birth control: _____ Are you contemplating pregnancy? ☐/☐
Yeast infections when taking antibiotics? Y / N ☐ / ☐
**Allergies to medications and type of reaction:** _____
**Medications** (Prescription, Non-Prescription, Vitamins): _____
_____

**SOCIAL HISTORY:** Please circle all that apply.

| | |
|---|---|
| MARITAL STATUS | Single ☐ Married ☐ Divorce ☐ Widow ☐ |
| CIGARETTE SMOKING | Never smoked ☐ Quit (former smoker) ☐ Smokes less than daily ☐ Smokes daily ☐ |
| ILLICIT DRUG USE | None ☐ Drug Use ☐ IV drug use ☐ |
| ALCOHOL USE | None ☐ Less than 1 drink a day ☐ 1-2 drinks a day ☐ 3 or more drinks a day ☐ |
| SAFETY | I feel safe at home ☐ I do not feel safe at home ☐ |
| BLOOD THINNER | ☐ ☐ |
| ASPIRIN | ☐ ☐ |
| RECENT VACCINATIONS: | _____ |

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**Name:** _____**Date:** _____

**Account # (for office use only)**_____

***Thank you for choosing Bellaire Dermatology for your skin care needs!***

**What is the main reason for today's visit?**

_____

**Are there any specific questions you would like answered?**

_____

**What additional services would you like to learn about?** ***(Please circle all that apply.)***

| | | |
|---|---|---|
| ☐ Skin care advice | ☐ Facial Veins | ☐ Double chin |
| ☐ Skin care products | ☐ Facial Redness | ☐ Spider/Varicose Vein |
| ☐ Fine lines and wrinkles | ☐ Brown spot/Freckles | ☐ Skin Laxity |
| ☐ Thin lips | ☐ Drooping Brow | ☐ Dark circle under eyes |
| ☐ Eyelash fullness and thickness | ☐ Drooping Eyelids | ☐ Body Contouring |
| ☐ Chemical peels | ☐ Mole Removal | ☐ Unwanted Hair |
| ☐ Acne scars/Scar treatment | ☐ Neck Wrinkles | ☐ Acne |
| ☐ Cellulite | ☐ Hand Rejuvenation | ☐ Sensitive skin (allergy to products) |

How did you hear about us?_____

How can we best contact you: Phone_____OK to text: ☐☐

Email_____

**I would like to be contacted about upcoming specials, events or informational sessions.**

____YES ____NO

**____ I'm not interested in any additional services or products at this time.**