



## DERMATOLOGICAL ASSOCIATION OF TEXAS

451 N. Texas Ave.                      6655 Travis St. #100                      20320 Northwest Fwy. #700  
Webster, TX 775988                      Houston, TX 77030                      Houston, Texas 77065  
281-333-3376                      713-528-8818                      713-554-4688  
Fax: 281-335-4605                      Fax: 713-528-8848                      Fax: 832-478-5662  
Stephen Tyring, MD, PhD                      Karan Sra, MD  
Lauren Campbell, MD                      Vandana Madkan, MD

### NEW PATIENT FORMS

**Welcome to our office.** Providing you with exceptional care is the motivation and intention of our physicians and staff.

We appreciate you taking the time to complete these New Patient Forms thoroughly so that we can enter this vital information into your permanent record. This information is critical to us in assisting you with the care, treatment and management of your dermatological conditions.

There are several pages for you to fill out.

The first is a **REGISTRATION FORM** requesting patient and insurance information. Your signature and date at the bottom are required.

Next is a two-page **MEDICAL HISTORY** questionnaire. We must know the details of your current and prior medical condition in order to provide you with quality health care.

Another page details your **FINANCIAL RESPONSIBILITIES** and your rights concerning privacy of your **PROTECTED HEALTH INFORMATION**. Please read these policies and sign and date in both places.

If you are on **MEDICARE** and/or have a **MEDIGAP** policy there is an additional page of statements that you must read and sign.

Finally, we have included a **Consent to Treat** form, just letting you know that some procedures might be applied to your deductible.

If you need assistance completing these forms, our receptionist will be happy to help when you arrive for your appointment.

#### EMAIL OR FAX COMPLETED FORMS PRIOR TO YOUR APPOINTMENT TO:

Email: [registration@dermtexas.com](mailto:registration@dermtexas.com)

Fax: Webster 281-335-4605

TMC 713-528-8848

Cypress 832-478-5662

or bring them with you to your appointment.

Thank you for your cooperation. We look forward to providing exceptional care for you and your skin!

**DERMATOLOGICAL ASSOCIATION OF TEXAS**



## PATIENT DEMOGRAPHIC INFORMATION

Please **PRINT** clearly and complete **ALL** sections

CLEAR LAKE AREA  
451 N. Texas Ave.  
Webster, TX 77598  
281-333-3376  
Fax: 281-335-4605

TEXAS MEDICAL CENTER  
6655 Travis, Suite 100  
Houston, TX 77030  
713-528-8818  
Fax: 713-528-8848

CYPRESS  
20320 Northwest Freeway, #700  
Houston, Texas 77065  
713-554-4688  
Fax: 832-478-5662

### PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname/Other Name
Home Address: Number & Street Name			Apt./Unit #
City	State	Zip Code	
Home Phone	Cell Phone	Work Phone	
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	How did you hear about us? <input type="checkbox"/> Physician <input type="checkbox"/> Friend <input type="checkbox"/> Radio <input type="checkbox"/> Magazine <input type="checkbox"/> Other	Name _____ Which one? _____

### INSURANCE INFORMATION

Primary Care Physician	PCP Phone	Referring Physician	Ref. Physician Phone
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you the insured or a dependent? <input type="checkbox"/> Insured <input type="checkbox"/> Dependent	
Primary Insurance Company Name	Primary Insurance Address	Phone	
Name of Insured: Last Name, First Name and Middle Initial (if patient is dependent)			Insured's Date of Birth
Insured's Address: Street, City, State & Zip (if different from patient)			Insured's Phone Number
Patient's relationship to insured	Name of Primary Parent/Guardian: Last Name, First Name & Middle Initial (if patient is a minor)		
Secondary Insurance Company Name	Address	Phone	
Name of Insured (if not patient)	Date of Birth	Relationship to patient	

### MEDICAL INFORMATION PREFERENCES

May we email you medical information or appointment reminders?  Yes  No Email Address: \_\_\_\_\_

May we leave messages regarding medical information or appointment reminders on your:  
 home phone?  Yes  No cell phone?  Yes  No work phone?  Yes  No **Brief Extended**

Race:  White  Black  Asian  Native American Indian  Other Ethnicity:  Hispanic  Non-Hispanic

Pharmacy Name Pharmacy Address: Number, Street, City and Zip Pharmacy Phone

### EMERGENCY & CONTACT INFORMATION

In case of emergency, who should we contact: Name	Home Phone	Other Phone	Relationship to patient
Are there other family members or persons with whom you authorize us to discuss your medical information? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:			
Last Name, First Name, Middle Initial	Phone	Relationship	
Last Name, First Name, Middle Initial	Phone	Relationship	

### SIGNATURE

Patient Signature	Date
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I hereby affirm that I am the legal parent or guardian of patient and have authority to make decision regarding medical treatments.

Parent/Guardian: Last Name, First Name, Middle Initial

Parent/Guardian Signature



**LIST ALL SIGNIFICANT HOSPITALIZATION(S) AND/OR SURGICAL PROCEDURE(S):**

Description	Month/Year

**FAMILY MEDICAL HISTORY**

Mother             Alive    Age \_\_\_\_                     Deceased    Cause of Death \_\_\_\_\_  
 Father             Alive    Age \_\_\_\_                     Deceased    Cause of Death \_\_\_\_\_  
 # Children \_\_\_\_    # Siblings \_\_\_\_  
 Family history of:    Skin Cancer     Other Cancer     Shingles     Herpes/Cold Sores

**PERSONAL/SOCIAL HABITS AND HISTORY:**

Do you use tobacco products?                     No     Yes    Type/Amount \_\_\_\_\_  
 Do you drink alcohol?                             No     Yes    # of drinks per week \_\_\_\_  
 Do you use recreational drugs?                 No     Yes    Type \_\_\_\_\_  
 Have you been exposed to HIV?                 No     Yes  
 Have you been exposed to Hepatitis?          No     Yes  
 Amount of daily sun exposure?                 Low     Medium     High  
 Do you use sunscreen?                             No     Yes    SPF \_\_\_\_  
 Do you use tanning beds?                         No     Yes    # of times per month \_\_\_\_  
 Marital Status                                         Single     Married     Committed Relationship  
 Occupation    Full Time     Part Time    Type of work \_\_\_\_\_     Retired

**OTHER MEDICAL INFORMATION**

Have you had a change in the color of your moles?                     Yes     No  
 Do you have dry or sensitive skin?     Yes     No  
 Do you have a pacemaker or defibrillator?                                     Yes     No  
 Do you have a tendency to develop keloids?                                     Yes     No  
 Are you allergic to tape or bandages?     Yes     No  
 Are you allergic to topical antibiotics?     Yes     No  
 Do you take aspirin or medication to thin your blood?                     Yes     No  
 Do you have problems with your immune system?                                 Yes     No  
 Do you experience excessive sweating?     Yes     No  
 Do you have bleeding problems?     Yes     No  
 Do you have problems with your finger or toe nails?                                 Yes     No



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### POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

Prior to seeing a medical professional at DAT, a staff member will discuss with you the likely costs involved in your procedure(s) and review your financial responsibility.

We accept certain insurance plans; therefore please provide us with your insurance card. We will let you know if your plan is one for which we are a designated provider. If you wish to be seen at DAT, you are responsible for payment of all co-pays and or deductible charges at the time of service. If your insurance is a plan for which we are not a designated provider, we are more than willing to provide care and you will be responsible for payment at the time of service.

Please remember that insurance policies may not cover all conditions and fees. To be fully aware of your schedule of benefits, please read your insurance policy or talk with an insurance representative.

Some procedures performed at DAT are considered cosmetic and will not be covered by insurance. Any laboratory analysis that we require, but do not perform in-house will be sent to an external laboratory as required by your insurance. You may receive a separate bill for laboratory services.

We accept Medicare and will file all claims for patients with Medicare. Please give us your secondary insurance card and we will also file it.

We accept payment in the form of cash, check, credit or debit card. Any checks returned to us due to insufficient funds will result in a fee of \$25.00 each.

If you are not going to be able to attend a scheduled appointment, 24 hours advance notice is requested.

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided by DAT, and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

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

\_\_\_\_\_  
Date

### HIPAA PRIVACY PRACTICES

As required as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a section concerning Patient Rights under the law. The Notice is available to you at the front desk at your request. You may review the Notice before signing this consent. The patient has the right to restrict the uses of their information.

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your health insurance company and overall health care operations. You have the right to revoke this consent in writing with your signature.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date



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## MEDICARE & MEDIGAP PATIENTS

### MEDICARE

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

*I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand that I can revoke this authorization in writing at any time.*

\_\_\_\_\_  
Signature of Patient as it appears on Medicare card

\_\_\_\_\_  
Date

### MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which Medicare automatically "crosses over," we are required to keep a separate signature on file. Please read and sign the statement that follows:

*I request authorized Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.*

\_\_\_\_\_  
Signature of Patient as it appears on Medigap card

\_\_\_\_\_  
Date



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### Treatment Consent Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize Dermatological Association of Texas physicians to treat or my dependent.

I understand that any treatment/procedure other than an Office Visit (such as Liquid Nitrogen and biopsy) may not be covered under my co-pay but might be applied to my deductible

#### **Acknowledgement**

I certify that I have read and fully understand the contents of this permission for the treatment and I agree to pay any balance that is applied to my deductible.

\_\_\_\_\_  
Signature - Patient or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature – Witness

\_\_\_\_\_  
Date