



DERMATOLOGICAL ASSOCIATION OF TEXAS

451 N. Texas Ave.
Webster, TX 775988
281-333-DERM (3376)
Fax: 281-335-4605
Stephen Tyring, MD, PhD
Saira George, MD

6655 Travis St. #100
Houston, TX 77030
713-528-8818
Fax: 713-528-8848
Karan Sra, 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 an optional form if you are interested in our skin care treatments and products.

If you are completing these documents prior to your appointment, you may fax them to us at 281-335-4605 or just bring them with you to your appointment.

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:

registration@dermtexas.com

Fax: 281-335-4605

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!

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PATIENT DEMOGRAPHIC INFORMATION

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

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

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

Date:

PATIENT INFORMATION

Last Name		First Name		Middle Initial	Nickname/Other Name
Home Address: Number & Street Name					Apt./Unit #
City		State		Zip Code	
Home Phone		Work Phone		Cell Phone	
Date of Birth					
Gender <input type="checkbox"/> M <input type="checkbox"/> F					

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

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:		Home Phone	Other Phone	Relationship to patient
Name				
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

Fax completed form, photo ID and insurance card to: Clear Lake office 281-335-4605 Texas Medical Center Office 713-528-8848

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 are



processed by A First Data Company. Telecheck fees for returned checks vary by the amount of the check.

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



INFORMED PATIENT CONSENT FOR ELECTRONIC MESSAGING

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WWW.DERMTEXAS.COM

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Our office will be happy to respond to your queries via email or telephone, but to do so via email you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any protected health information that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your query.

If you wish to conduct PHI discussions via email, please indicate your acceptance of this risk with your signature below. Alternatively, please call our office to arrange a phone conversation or office visit.

I authorize Dermatological Association of Texas to communicate PHI via email.

I DO NOT authorize Dermatological Association of Texas to communicate PHI via email.

SIGNATURE

Patient Signature

Date

Patient Name (Print)

DOB

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