SURGICAL DERMATOLOGY ASSOCIATES DALLAS, P.A.

One Forest Medical Plaza
12200 Park Central Dr. Suite
215 Dallas, TX 75251
P: 972-239-6999
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PATIENT REGISTRATION

Date: _____ Date of Birth ____/____/____ Sex: ○ M or ○F

Patient Name (○Dr. ○ Mr. ○ Mrs. ○Ms.) _____
LAST FIRST MIDDLE

Home Address _____
STREET APT.NO. CITY STATE ZIP

Home Phone (____) _____ Cell Phone (____) _____ Work (____) _____

Call preference: ☐Home ☐Work ☐ Cell Email address: _____

Marital status: ☐Single ☐ Married ☐Divorced ☐Widowed

Occupation: _____ Employer: _____

Emergency contact: _____ Phone #_____ Relationship: _____

Who referred you to our practice?: _____

Name of current dermatologist: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance: _____
Insurance Address: _____
_____
Ins. Phone # _____
ID# _____
Group # _____

Policy issued to: _____
Address and phone #: ☐same as above
_____
_____

Insured D.O.B. _____
Relationship to patient: _____
Sex: M or F
Employer _____

Secondary Insurance: _____
Insurance Address: _____
_____
Ins. Phone # _____
ID# _____
Group # _____

Policy Issued to: _____
Insured's address: ☐same as above
_____
_____

Insured D.O.B _____
Relationship to patient: _____
Sex: M or F
Employer: _____

SURGICAL DERMATOLOGY ASSOCIATES DALLAS, P.A.

Name:_____

DOB:_____

TELEPHONE INFORMATION and COMMUNICATION RELEASE:

May we leave personal medical information on your answering machine or cell phone? ○ Yes or ○No

If yes, please check all that we leave information on: ○ Home phone ○Work phone ○Cell phone

May we email personal medical information to you? ○ Yes or ○No

Email address: _____

We may use email and/or text messaging for appointment reminders. Please initial here _____

I understand and agree that NO personal photos or videos are allowed during my procedure/appointment(s).

Signature: _____ Date: _____

Do you give our office permission to discuss your medical information with family members?
○ Yes or ○No If yes, please provide their names below.

I authorize Surgical Dermatology Associates to disclose my medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, or any other such related information to these listed below (physician, family member):

Name	Telephone #	Relationship
Name	Telephone #	Relationship
Name	Telephone #	Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

Signature of patient/Legally authorized representative	Date	Relationship

Print Name	Date

SURGICAL DERMATOLOGY ASSOCIATES DALLAS, P.A.

Name:_____

DOB:_____

Health History Form

Preferred Pharmacy Name:_____Phone: _____

Pharmacy Location: Address or intersection: _____

Please check yes or no if you have or have had each of the following:

	Yes	No		Yes	No
Asthma	☐	☐	Diabetes	☐	☐
COPD	☐	☐	Organ Transplant:_____	☐	☐
Cancer (non-skin)	☐	☐	Bone Marrow Transplant	☐	☐
Kidney Problems	☐	☐	Hypertension	☐	☐
Dementia	☐	☐	Chest Pain/Angina	☐	☐
Psychiatric care	☐	☐	Cardiac Stent Date:_____	☐	☐
HIV/AIDS	☐	☐	**Defibrillator**	☐	☐
Hepatitis B	☐	☐	**Pacemaker**	☐	☐
Hepatitis C	☐	☐	Blood Clots	☐	☐
Herpes Labialis/Fever Blisters	☐	☐	DVT	☐	☐
Keloids/Hypertrophic Scars	☐	☐	Stroke	☐	☐
Skin Cancer: (*prior to this time*)			TIA	☐	☐
Basal cell carcinoma	☐	☐	Require oxygen	☐	☐
Squamous cell	☐	☐	**Artificial Joints** Date(s):_____	☐	☐
Melanoma	☐	☐	Heart Valve problems	☐	☐
Other	☐	☐	Artificial Heart Valve	☐	☐
Low platelets or bleeding disorder	☐	☐	Rheumatic Fever	☐	☐
Women: Are you pregnant or nursing?	☐	☐	Cirrhosis	☐	☐

Have you had Mohs surgery before: □ Yes □ No by Dr._____Date(s):_____

Family History of Skin Cancer: _____

Other Medical Problems	**Previous Surgeries**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications, vitamins and herbal supplements:_____

_____

_____

_____

Do you have any implanted medical devices (ports, shunts stimulators, etc.) _____

Circle if you are taking: Aspirin Plavix/Effient/Pradaxa/Ticlid Ibuprofen Heparin/Lovenox

Eliquis Xarelto Coumadin (**Last INR:**_____ **Date:** _____)

Are you allergic to any medications? □***Yes*** □***No*** **If yes, please list:** _____

Are you allergic to Latex? Yes/No

Do you live in a nursing home or assisted living facility? □ Yes □ No

Do you live alone? □ Yes □ No

Is the patient able to give informed consent**?** □ Yes □ No If no, who has power of attorney: _____

Today's Date: _____

SURGICAL DERMATOLOGY ASSOCIATES DALLAS, P.A.

Name:_____

DOB:_____

PATIENT FINANCIAL POLICY

Thank you for choosing our office for your care. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions regarding this policy, please discuss them with our practice manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of this policy as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have out-of-network benefits we will be happy to assist you with filing the claim. Therefore, our charges for your care and treatment are due at the time of service. In the event your health plan determines a service is "not covered," "not medically necessary" or a "cosmetic procedure" you will be responsible for the complete charges.
- For services rendered to minor patients, the accompanying parent or guardian is responsible for payment.
- Although benefits may be verified at time of service, please note this is not a guarantee of payment.
- Patient balances are due within 30 days of receipt of statements. At that point, additional charges may be applied. We will work with you to make payment arrangements. If these efforts do not result in resolution of the account, the account may be referred to a collection agency; you will be responsible for any and all fees charged by the collection agency. These fees will be added to your account.
- If your insurance plan denies payment for any reason, you will be responsible for payment. It is your responsibility as the patient to pay the denied amounts in full.
- If you need laboratory services (pathology, wound culture), you will receive a separate bill from the pathology laboratory for said tests.

24 HOUR CANCELLATION POLICY: Please provide our office with a 24-hour notice to change or cancel an appointment. If you do not appear for your appointment or cancel with less than 24 hours notice, you will be charged a fee of $25 for missed office visits or $150 for missed surgical/procedure appointments. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. We realize that emergencies and other conflicts arise and are sometimes unavoidable, however, advance notice allows us to keep the clinic operating at a most efficient level.

PAYMENT POLICY: *It is my responsibility to confirm that the physician is a covered provider under my insurance plan*. I hereby authorize the assignment of benefits (payments) directly to Surgical Dermatology Associates for all my insurance claims related to services received. I understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles with any managed care contract and non-covered services. I have read, understood, and agree to the financial and cancellation policies above.

Signature (insured person) _____ Date _____

AUTHORIZATION TO PAY BENEFITS PHYSICIAN: I hereby authorize Surgical Dermatology Associates to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit to insurance companies.

Signature (insured person) _____ Date _____

MEDICARE PATIENTS ONLY:

MEDICARE RELEASE: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. Photocopy shall be valid as original.

Signature (insured person) _____ Date _____

SECONDARY RELEASE: For Medicare patients with supplemental Secondary Insurance, a separate signature is needed. I request Secondary Insurance benefits be made on my behalf for services rendered. I authorize to be released to my Secondary carrier any information needed to determine benefits.

Signature (insured person) _____ Date _____