WHITE ROCK DERMATOLOGY

10611 Garland Road, Suite 210; Dallas, TX 75218 Tel: 214-324-2881

Date: _____

Patient's Full Name: _____ Gender: _____ Age: _____

Marital Status: Single_____ Married_____ Widowed____ Divorced____

DOB: _____ Social Security Number: _____ Occupation: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Employer: _____

Spouse/Parent Name: _____ Work Phone: _____

Please provide the following information for the person who will be responsible for the payment of medical bills (if different from above):

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Emergency Contacts:

Nearest relative not living with you: _____ Phone: _____

Relationship: _____

Nearest friend not living with you: _____ Phone: _____

Referred by: _____ ( ) Doctor ( ) Family ( ) Friend ( ) Ins. Plan ( ) Phone Book

Name of Family Physician: _____

Covered by health insurance? ( ) Yes ( ) No If yes, the name of your plan: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE:

Name of Parent/Guardian: _____ Work #: _____ Employer: _____

If I find that I am unable to accompany my above child/young adult to an appointment, I hereby grant to White Rock Dermatology permission to examine and treat my child is and when he/she arrives at the office unaccompanied.

_____ _____

Signature of Parent/Guardian Date

Name:_____Date:_____

Current Skin Problems: State in your own words the problem for which you are seeking treatment:

	Skin Problem and Location	**Duration**	**Previous Treatment**
1.			
2.			
3.			

IMPORTANT: Are you allergic to any medications? ( ) Yes ( ) No If yes, please list them:

Please list any medications that you are currently taking or take more than occasionally (or provide a list):

MEDICAL HISTORY: (Please check if you have had the following):

( ) Hay Fever/Asthma	( ) Kidney Disease	( ) Eczema	( ) Yeast Infections
( ) Peptic Ulcer	( ) Tuberculosis (TB)	( ) High Blood Pressure	( ) Cancer
( ) Diabetes	( ) Heart Disease	( ) Bleeding Tendency	( ) Epilepsy
( ) Hepatitis/Liver Disease	( ) Hives	( ) Thick Scars (Keloids)	( ) Thyroid Disease

( ) Other Illnesses (please specify)_____

Do you smoke?_____Drink Alcohol?_____Special Diet?_____Exercise Routinely?_____

Do you have a heart pacemaker? ( ) Yes ( ) No

Women: Are you pregnant? ( ) Yes ( ) No If yes, your due date:_____

HISTORY OF SKIN PROBLEMS:

Previous Skin Diseases:_____

Have you been under the care of a dermatologist within the past five years? ( ) Yes ( ) No

Personal history of skin cancer: ( ) Yes ( ) No Type:_____

Risk factors for skin cancer: ( ) Radiation Exposure ( ) History of Multiple Sunburns

( ) PUVA Treatments ( ) Chronic Immunosuppression (organ transplantation, chemotherapy, AIDS)

Family history of skin cancer: ( ) Yes ( ) No If yes, who and type:_____

Family History of Skin Disease (please specify):_____

Please provide any information not included above which you believe is important for the doctor to know:

My signature below signifies that the above information is correct to the best of my knowledge and provides my consent for examinations necessary to diagnose and treat my skin conditions:

Patient/Guardian Signature:_____Date:_____Dr's initials:_____Date:_____

This form was completed by: ( ) Patient ( ) Spouse/Parent ( ) Other:_____

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Telephone: 214-324-2881 Fax: 214-324-4084

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Not infrequently we are asked to provide medical information related to your care to your primary care physician and/or to your insurance carrier to resolve issues related to charges. Spouses and/or children frequently request the results of laboratory studies and biopsy reports. Without your authorization, we cannot provide such basic information to anyone except you, the patient. This simple form is to allow you to provide that authorization, or to specifically deny such authorization when appropriate

I hereby authorize the release of information from my medical record to the following:

_____ Primary Care Physician
_____ Other Specialty Care Physician from whom I receive care
_____ Spouse
_____ Parents
_____ Children and their spouses
_____ Other (specify) _____

(Please check any of the above that you specifically wish to include)

I understand that information released is for the purpose of providing quality continued patient care. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

May we leave medical information on your home or cellphone voicemail if unable to reach you: **YES NO** (Please circle appropriate response)

Patient Name _____ Date of Birth _____

_____ _____
Signature of Patient or Legal Representative Date
Parent or Legal Guardian must sign for patient under 18 years of age

_____ _____
Relationship to Patient if other than self Witness

PLEASE SIGN SO WE HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, that I am responsible for all charges. I authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical benefits to which I am entitled to White Rock Dermatology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient/Guardian Signature: _____ Date: _____

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Financial Policy

If we are not filing insurance for your visit, you are responsible for payment in full at the time of service. We accept cash, checks, Mastercard, Visa, and Discover.

Patients covered by contracted insurance plans

It may be necessary to perform minor procedures during your visit. **In addition to your office visit co-pay, covered procedures may be applied to your deductible and/or coinsurance.** It is up to you to understand the financial responsibilities required of you by your insurance policy.

We routinely freeze precancerous lesions & warts and biopsy suspicious lesions for pathology. Some of these CPT procedure codes are:

Precancerous lesion destructions 17000, 17003
Benign lesion destructions 17110, 17111
Incision & drainage (simple) 10060 or (complicated) 10061
Excision/closure of skin cancers or cysts 11401~11606, 12031~13132
Biopsies 11100, 11101
Pathology 88305
Skin Tags 11200, 11201

You may wish to review these procedures with your insurance company before your visit (this is NOT a complete list of procedures)

LAB BENEFITS

Out biopsy specimens are sent to **Propath Labs (214) 631-6721**. If your insurance plan requires you to use a different lab, it is your responsibility to inform us prior to your appointment. If you are unsure, please contact your insurance company before your appointment. Otherwise, we will send your specimens to **Propath**.

I understand and agree to the financial responsibilities listed above.

Patient/Guardian Signature: _____ Date: _____

WHITE ROCK DERMATOLOGY

WRITTEN ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT FORM

Our Notice of Privacy Practices provides information as to how we may use and disclose protected health information about you. You have been given a copy of our Notice of Privacy practices. The terms of our Notice may change. You may obtain a revised copy by contacting our office.

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By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices and consent to the disclosure of protected health information about me for treatment, payment, and health care operations as described by the Notice of Privacy Practices. White Rock Dermatology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature of Patient or Patient Representative **Date**

_____

Relationship to Patient
(if signed by other than patient)