SURGICAL DERMATOLOGY ASSOCIATES DENTON, P.A.

Bryden Building 1
4851 South I-35E, Suite 101
Corinth, Texas 76210
(P) 940-591-0900 (F) 940-220-6444

PATIENT REGISTRATION

Date: _____ Date of Birth_____/_____/_____

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

Home Address_____
STREET APT.NO. CITY STATE ZIP

Mailing Address_____
STREET APT.NO. CITY STATE ZIP

Home Phone (_____)_____ Cell Phone (_____)_____Work (_____)_____

SS# _____ Marital status: ☐Minor ☐Single ☐ Married ☐Divorced ☐Widowed

Sex: ○ M or ○F Occupation_____ Employer _____

Work Address _____
STREET . CITY STATE ZIP

Who referred you to our practice?_____

Name of **Primary Care Physician**:_____Phone:_____

Name of Dermatologist if you have one:_____Phone:_____

INSURANCE INFORMATION:

Primary Insurance:_____ Secondary Insurance: _____

Insurance Address: _____ Insurance Address: _____

_____ _____

Ins. Phone # _____ Ins. Phone # _____

ID# _____ ID# _____

Group # _____ Group # _____

Policy issued to: _____ Policy Issued to: _____

Address and phone #: ☐same as above Insured's address: ☐same as above

_____ _____

_____ _____

D.O.B. _____ D.O.B. _____

SS# _____ SS# _____

Relationship to patient: _____ Relationship to patient: _____

Sex: M or F Sex: M or F

Employer _____ Employer _____

In the event of an emergency, whom should we contact?

Name: _____

Relationship _____ Home #_____Cell or Work# _____

SURGICAL DERMATOLOGY ASSOCIATES DENTON, 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 procedures/appointment(s). Please Initial here _____

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 the 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 DENTON, P.A.

Name:_____

DOB:_____

Health History Form

What is the purpose of your visit today? _____Date:_____

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	❑	❑
Women: Are you pregnant or nursing?	❑	❑	Rheumatic Fever	❑	❑
Low platelets or bleeding disorder	❑	❑	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:_____

_____

_____

Electronic Health Information: I give permission to SDA to access my external prescription history: □ Yes □ No

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

Circle if you are taking: Aspirin Plavix/Effient/Pradaxa/Ticlid Ibuprofen Heparin/Lovenox
Coumadin (**last INR**:_____**Date** :_____) Xarelto Eliquis

List Medication Allergies:_____ ***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
Do you smoke? □ Yes □ No
Do you use smokeless tobacco? □ Yes □ No
Do you drink alcohol? □ Yes □ No (Drinks/day:_____)
Do you use, or have you used any illicit or street drugs? □ Yes □ No (Type:_____)

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

SURGICAL DERMATOLOGY ASSOCIATES DENTON, P.A.

Name:_____

DOB:_____

PATIENT FINANCIAL POLICY

Thank you for choosing our office for your care. We are dedicated in 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. To ensure a smooth and transparent process regarding your financial responsibilities, we have outlined our patient financial policy below:

- Payment is due at the time service is provided. You are responsible for all deductibles, co-payments, and co-insurance which is estimated at the time of service. For your convenience, our office accepts cash or personal checks, all major credit and, or debit cards, and CareCredit third-party financing.
- As a courtesy, we will help process insurance claims. Please understand we will provide an estimate of coverage. This is not a guarantee the estimate is accurate as benefits may differ for many reasons specifically related to your plan and individual coverage.
- All charges are your responsibility regardless of insurance coverage. Your insurance policy is a contract between you and the insurance company, our office is not a party in that contract.
- 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.
- Unaccompanied Minors: The parent or legal guardian is responsible for full payment at the time of services. Treatment consent and payment arrangements should be made prior to the appointment.
- If your insurance company has not made a payment within 60 days, we will ask you to contact your insurance company. If your insurance plan denies payment for any reason, you will be responsible for payment. Patient balances are due within 30 days of receipt of statements. At that point, additional charges may be applied.
- If you need laboratory services (pathology, wound culture), you will receive a sperate bill from the pathology laboratory for said test.

24 HOUR CANCELLATION POLICY: To provide the best services to our patients, **we require 24 hours' notice for cancellations**. We understand unforeseen circumstances may arise. A charge may be assessed for multiple missed or short notice cancels. Multiple failed appointments may result in being dismissed from the practice.

ASSIGNMENT OF BENEFITS:

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.

Signed (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.

Signed (insured person)_____ Date_____

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.

Signed (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.

Signed (insured person)_____ Date_____