Texas Surgical Dermatology PA
Experience the Excellence in Dermatology

Today's Date: _____

Provider seeing you today: ☐ Dr Nguyen ☐ Dr Hughes ☐ Nurse Rosann

How did you hear about us? (please check all that applies)

☐ Another patient ☐ My doctor ☐ Insurance Referred ☐ Website/Internet

Other: _____

Patient Name: Last _____ First _____ Birth date: _____

How do you prefer to be addressed? _____

Gender: ☐ Male ☐ Female Social Security Number: _____ - _____ - _____

Address (Street, City, State, Zip Code): _____

Email (We only contact you about your care): _____

Home phone: _____ Cell Phone: _____

What is your preferred method of contact? ☐ Email ☐ Home Phone ☐ Cell/Text

Preferred Pharmacy: _____ Phone: _____

Address: _____

Emergency Contact -Full Name: _____ Phone:_____

May we discuss your medical information with this person? ☐ YES ☐ NO

Relationship to you: _____

Signature: _____ **Date:** _____

Date: _____ Patient name _____ Birthdate _____

Self-Pay? ☐ YES ☐ NO. If Yes, then please skip to Important Notices below.

Insurance - Financial Information

Primary Insurance:_____ Policy number: _____

Phone Number Primary Insurance: _____

Secondary Insurance: _____ Policy number: _____

Phone Number Secondary Insurance: _____

Name Policy Holder: _____ Birthdate Policy Holder: _____

Social Security Number of Policy Holder (if different than patient): _____

Relationship of Policy Holder to Patient: ☐ SELF ☐ OTHER: _____

IMPORTANT NOTICES: If a biopsy is performed during your visit, the specimen will be sent to an outside pathology lab for diagnosis. You will be billed *separately* for this service from the pathologist.

I understand that I am responsible for any additional charges that may result from procedures done in the office that are not included in my copay, and for any charges due to my deductible in cases where my deductible has not been met.

I understand that if any services or charges are not covered by my insurance carrier, or my eligibility cannot be verified, that I am responsible for all charges incurred.

I understand that payment is due at the time of service.

Assignment of Insurance Benefits and Authorization for Release of Information

I request that payment of authorized Medicare, Medigap or other insurance benefits be made on my behalf to **Texas Surgical Dermatology PA** for any services furnished to me by its providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) , its agents, my insurer, or any organization any information needed to determine these benefits or as required for certain claims to be filed. This authorization shall continue until such time as I revoke it in writing.

By signing below, I am verifying that the information above is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Date: _____ Patient name _____ Birthdate _____

Referring Doctor:_____

Address (Street, City, State, Zip Code): _____

_____

Phone:_____ Fax:_____

Primary Care Doctor: (if different from above) _____

Address (Street, City, State, Zip Code): _____

_____

Phone:_____ Fax: _____

How can we help you? *Please check all that apply*

☐ Changing Lesion ☐ Worrisome spot ☐ Skin Cancer ☐ Rash

☐ Vein evaluation ☐ Scar Revision ☐ Cosmetic Consult ☐ 2nd Opinion

Other reasons for visit_____

_____

Social History

Occupation: _____Retired☐

Marital Status ☐Married ☐Single ☐Divorced ☐Widowed

Spouse/Partner's name _____

How many children do you have? _____

Do you live by yourself? ☐Yes ☐No

Do you smoke or chew? ☐Yes ☐No If Yes, how much?_____

_____

Do you drink alcohol? ☐Yes ☐No If Yes, how much?_____

_____

Date: _____ Patient name _____ Birthdate _____

Do you faint or feel light headed with blood draws or with surgery? ☐ Yes ☐ No

ALLERGIES	What reaction do you have to this drug?
1	
2	
3	
4	
Do you have any other reactions or precautions we should know?	

Vitamins /Herbals/ Over the Counter Medications:

_____

_____

Please list your medications	**Directions/Dosage (if known)**
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

Date: _____ Patient name _____ Birthdate _____

Personal Skin Cancer History:

	☐ None		If yes, where?
Melanoma	☐ Yes	☐ No	_____
Basal Cell Cancer	☐ Yes	☐ No	_____
Squamous Cell Cancer	☐ Yes	☐ No	_____
Actinic Keratosis (Precancer)	☐ Yes	☐ No	_____
Have you had skin cancer surgery?	☐ Yes	☐ No	_____

Other:_____

Family Skin Cancer History:

	☐ None		If Yes, who?
Melanoma	☐ Yes	☐ No	_____
Basal Cell Cancer	☐ Yes	☐ No	_____
Squamous Cell Cancer	☐ Yes	☐ No	_____

How sensitive are you to the sun? *Please Check only one answer*

☐ I Always burn, never tan
☐ II Always burn, but sometimes tan
☐ III Sometimes burn, but always tan
☐ IV Never burn, always tan

Sun Protection Practices:

Do you wear sunscreens with UVA and UVB protection (broad spectrum) and SPF 30 or greater?	☐ Yes	☐ No
Do you wear a hat with 4 inch brim all around?	☐ Yes	☐ No
Do you wear long sleeve clothing?	☐ Yes	☐ No
Do you avoid sun exposure during peak sun hours (between 10 AM and 4 PM)?	☐ Yes	☐ No

Please list any rejuvenation or cosmetic products you are using: _____

_____

Would you like to learn more about rejuvenating your skin? ☐ YES ☐ NO

Date: _____ Patient name _____ Birthdate _____

Please check all that apply

- ☐ Previous cosmetic surgery
- ☐ **Pacemaker/Defibrillator**
- ☐ Brain stimulator
- ☐ Hip replacement- if yes when?
- ☐ Need antibiotics before dental surgery?
- ☐ Heart valve surgery
- ☐ Heart valve infection (endocarditis)
- ☐ Heart bypass surgery
- ☐ Heart rhythm problems
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Blood thinners
- ☐ Circulation problems (Arterial or Veins?)
- ☐ Blood clots in deep veins
- ☐ Pulmonary embolus (clot to lungs)
- ☐ Asthma
- ☐ Emphysema, COPD
- ☐ Tuberculosis
- ☐ Immune system problems
- ☐ HIV/AIDS
- ☐ Organ transplant patient (please list below): kidney, heart, lung, bone marrow, liver, pancreas
- ☐ Are you pregnant or may be pregnant?
- ☐ Diabetes
- ☐ Dialysis
- ☐ Kidney problems
- ☐ Liver disease/Cirrhosis
- ☐ Hepatitis A or B or C (circle all that apply)
- ☐ History of blood transfusions
- ☐ Bleeding problems (problems clotting)
- ☐ X-ray treatment for acne
- ☐ Radiation treatment for anything
- ☐ Anxiety or nervousness
- ☐ Psychiatric conditions
- ☐ Problems with local anesthesia
- ☐ Problems with general anesthesia
- ☐ Abnormal scarring or keloids
- ☐ Seizures
- ☐ Strokes
- ☐ Neck injuries or surgery
- ☐ Back injuries or surgery
- ☐ Raynaud's
- ☐ Autoimmune disease (please list below): Lupus, Scleroderma, CREST, Sjogrens, Dermatomyositis, Rheumatoid arthritis

☐ History of any cancer, other than skin cancer (circle all that apply): Breast, lung, colon, thyroid, kidney, prostate, bone , leukemia, lymphoma, sarcoma, brain, pancreas, ovarian.

Do you have any other medical issues not listed above?

_____

_____

_____

_____

Date: _____ Patient name _____ Birthdate _____

Please check all that apply (within past 3 months)

- ☐ unplanned weight loss, weight gain
- ☐ fevers, chills
- ☐ night sweats
- ☐ nausea and vomitting
- ☐ appetite or diet changes
- ☐ easily faints
- ☐ easily falls or balance problems
- ☐ unusual headaches
- ☐ sudden vision changes
- ☐ unusual change in coordination
- ☐ recent seizures (within past 3 months)
- ☐ black or bloody stools
- ☐ recent stomach pains (within 3 months)
- ☐ blood in urine
- ☐ problems controlling bladder
- ☐ swelling in groin, armpits, or neck
- ☐ bleeding in joints when injured
- ☐ difficulty lying flat
- ☐ neck pain
- ☐ chest pain or angina
- ☐ shortness of breath
- ☐ cough (bloody or greenish sputum)

Do you wish to share anything else that may help us care for you?

_____

_____

_____

_____

Thank you for your time and for helping us take care of you.