Patient Registration Form

Southwest Dermatology & Vein

PATIENT INFORMATION

Patient's Legal Name: (as it appears on Drivers License or Photo ID)			Patient's Preferred Name:	
Street Address:	Apt#:	City:	State:	Zip:
Email Address:	Would you like email confirmations? (Circle One) Yes | No		Would you like promo emails? (Circle One) Yes | No	
Social Security Number:			Date of Birth:	
Primary Phone:	Type: (Circle One) Cell|Home|Office		Secondary Phone:	Type: (Circle One) Cell|Home|Office
Preferred Contact Method: (Circle One) Text Message | Email | Phone			Birth Gender: (Circle One) Male | Female	
Race: (Circle One) White | Black | Latino | Other_____ | Decline to Specify			Marital Status: (Circle One) Single | Married | Widowed	
Ethnicity: (Circle One) Hispanic | Latino | Not Hispanic/Latino | Decline to Specify			Primary Care Physician (PCP):	

Referred to our Clinic By: (Circle One)

Dr._____ | Family/ Friend | Facebook | Yelp | Google | Print Ad | Other:_____

INSURANCE INFORMATION

Primary Insurance Carrier:	Primary Insurance Policy/ID #:	Primary Insurance Group #:
Primary Insurance Policy Holder's Name:	Primary Insurance Policy Holder's D.O.B.:	Patient's Relationship to Insured:
Secondary Insurance Carrier:	Secondary Insurance Policy/ID #:	Secondary Insurance Group #:
Secondary Insurance Policy Holder's Name:	Secondary Insurance Policy Holder's D.O.B.:	Patient's Relationship to Insured:

LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Southwest Dermatology & Vein Clinic and its related companies. I understand that I am financially responsible for any balance. I also authorize, its related companies, or insurance company to release medical information required to process claims. _____**(Initials)**

Notice of Privacy Practices: I have read or been offered a copy of Southwest Dermatology & Vein Clinic's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record. _____**(Initials)**

Consent for Communication: I understand Southwest Dermatology & Vein Clinic will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders. _____**(Initials)**

Payment Policy: Payment is due at time of service, including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Southwest Dermatology & Vein Clinic and its related companies. _____**(Initials)**

Legal: This form applies to Southwest Dermatology & Vein Clinic and its related companies including Southwest Dermatology, Southwest Skin Cancer & Vein Clinic and Southwest Skin and Vein Center PLLC. _____**(Initials)**

Signature: _____ **Date: _____**

Parent/Legal Guardian: _____ **Date: _____**

Medical History and Intake Form

Southwest Dermatology & Vein

Patient Name: _____ **Date of Birth:**_____

Pharmacy: _____
Name Address (Zip Code) Phone

□ **The clinic can discuss my care with:** _____
Name Relation Phone

□ **The clinic may leave a detailed message regarding medications or lab results.**

Primary Care Physician: _____ **Referring Physician:** _____

Past Medical History: (Check all that apply. If NONE, please check NONE)

□ Anxiety Disorder	□ Cancer*	□ High Blood Pressure	□ Hyperthyroidism
□ Arthritis*	□ Stroke	□ Kidney Disease*	□ Hypothyroidism
□ Asthma	□ Lung Disease*	□ Psychiatric Disease*	□ Myasthenia Gravis
□ Atrial Fibrillation	□ Depression	□ Heart Disease*	□ Gastrointestinal Disease*
□ Autoimmune Disease*	□ Diabetes Mellitus	□ Radiation	□ Vein Disease
□ Bone Marrow Transplant	□ Cervical Dysplasia	□ High Cholesterol	□ **NONE**

***Please list type/Other:**_____

Past Surgical History (Please list any prior non-skin related surgeries): □ See List

_____ _____ _____

Skin Disease History:

□ Acne	□ Dysplastic Nevus	□ Melanoma	□ Squamous Cell Carcinoma
□ Basal Cell Carcinoma	□ Eczema	□ Psoriasis	□ Family History of Melanoma

Other skin cancers: _____ Other skin disease: _____

Alerts:

□ Pregnancy	□ Pacemaker	□ Artificial Joints <2 yrs old	□ HIV
□ Breastfeeding	□ Defibrillator	□ Need Antibiotics for Procedures	□ Hepatitis B
□ Allergy to Adhesive	□ Brain/Spinal Stimulator	□ Immunosuppression	□ Hepatitis C
□ Allergy to Latex	□ Artificial Heart Valve	□ Organ Transplant	□ Blood Thinners

Cosmetics (Check any you have interest in):

□ Botox/Dysport	□ Fillers	□ Microneedling	□ Wrinkles/Fine Lines	□ Hair Loss
□ Chemical Peels	□ Skin Care	□ Red/Brown Spots	□ Thread Lift	□ PRP

□ Have you ever had a complication with a cosmetic procedure? _____

Leg Vein Screen (Check if you have had any of the following):

□ Cramping/Night Cramps	□ Leg Pain/Aching	□ Leg Itching	□ Leg Swelling	□ Leg Rashes

<u>Vaccinations</u>:

□ I have had a flu shot within the past 12 months □ I have had a pneumonia shot in the past 5 years

Current Medications, Vitamins, and Supplements: □ See List

_____ _____ _____

_____ _____ _____

_____ _____ _____

□ I am **<u>ALLERGIC</u>** to these medications:_____ □ **NO ALLERGIES**

Smoking Status: □ Never □ Former □ Current: # of packs per day: _____

Alcohol Status: How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Occupation: _____

Reason for Today's Visit: _____