Alamo City Dermatology

Patient Registration Form

First Name: _____ ***Middle:*** _____ ***Last Name:*** _____

Address: _____ ***City:*** _____ ***State***_____ ***Zip Code:***_____

Date of Birth: _____ ***SSN:*** _____ ***Phone Number:*** _____

Email: _____ ***Ok to leave a message? ☐ Yes ☐ No***

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated

Gender Identity: ☐Declined to say ☐ Male ☐ Female ☐ Transgender Male (Female to Male) ☐Transgender Female (Male to Female) ☐Non-Binary Gender ☐Other

Preferred Language: ☐English ☐Spanish ☐ Other: _____

Race: ☐Caucasian ☐African American ☐ Asian ☐ Native American ☐ Other

Ethnicity: ☐ Unspecified ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other

Insurance

Do you have medical insurance coverage? ☐Yes ☐No
Does your insurance card state "referrals required?" ☐ Yes ☐ No
Social Security Number of Policy Holder (If different from above):

Primary Insurance: _____ **Policy Holder:** _____

Second Insurance: _____ **Policy Holder:**_____

☐HMO ☐PPO ☐ Private Pay ☐ POS ☐ Medicare Advantage ☐Other

Are you in Hospice Care or Nursing Home? ☐ Yes ☐ No
Name of Agency: _____ Name of Provider: _____ Phone Number: _____

Primary Care Doctor

Name of Primary Care Doctor:	Phone Number:
Name of Referring Doctor:	Phone Number:

Pharmacy

Pharmacy Name:	Phone Number:
Pharmacy Street Address:	Zip Code:

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Financial Policy

All services rendered are charged to the patient or authorized individual. The patient or authorized individual is responsible for payment regardless of insurance coverage.
Full payment is expected at the time of each visit. In all instances when the patient is covered by a health insurance company with whom this office is a participating provider, we will verify eligibility and benefits directly with the insurance company. Please notify our office if your insurance has changed at least **24 hours** prior to your appointment. If we are not a provider with your new insurance, you will be treated as a private pay patient.

It is ultimately the responsibility of your insurance company to provide the education on the benefits available to you. All co-payments, coinsurance, and deductibles are due at the time services are rendered.

I hereby authorize Alamo City Dermatology to release medical information concerning my examination and/or treatment for insurance purposes and receive direct payment for medical benefits payable to me for the services rendered. I, the undersigned, have completed this registration form to the best of my knowledge. Furthermore, I have read and fully understand the payment policy & authorization of payment outlined above.

☐I understand that if I need letters or medical records for my personal use, I will be charged a fee according to the office policy.

Signature of Patient or Authorized Individual: _____ Date: _____

Cancelation Policy / No Show Policy

We understand that a situation may arise in which you must cancel or reschedule your appointment. Please give us the courtesy of calling no less than **24 hours** in advance to reschedule your appointment. Failure to do so will result in a missed appointment fee, NOT charged to your insurance.

For medical procedures, a $25.00 fee can be incurred if you:

1.) Do not show for your scheduled appointment
2.) Or do not notify our office 24 hours prior to canceling your scheduled appointment.

For cosmetic procedures, a $50.00 fee can be incurred if you:

1) Do not show for your appointment
2) Or do not notify our office 24 hours prior to canceling your scheduled appointment.

Signature of Patient or Authorized Individual: _____ Date: _____

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Consent to Treatment and Payment

I, _____, voluntarily consent to the rendering of health care services and medical treatment by authorized staff of Alamo City Dermatology for myself and/or above stated patient. I also authorize my insurance companies to reimburse Alamo City Dermatology for services rendered. I understand that I am responsible for all charges in connection with the care and treatment rendered. I also understand that all payments including deductibles and copays are due at time of service.

Signature of Patient or Authorized Individual: _____ Date: _____

OTHER

How did you hear about us?

Referred by: DR._____

☐Family Member / Friend

☐Google

☐Yelp

☐Website

☐Social Media Platform (Facebook, Instagram, Yelp, Twitter, other).

Are you interested in discussing any cosmetic treatments during your visit?
☐Yes ☐No

Are you interested in being featured on our social media platforms?
☐Yes ☐No

Connect with us!

Last revised: 11/2020

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Reason for Visit

Past Medical Conditions

- ☐ Anxiety disorder
- ☐ Arthritis
- ☐Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by COVID-19
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ H/O Hypertension
- ☐ Hearing loss
- ☐ Human immunodeficiency virus infection
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Inflammatory disease of the liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of the lung
- ☐ Malignant tumor of the breast
- ☐ Malignant tumor of the colon
- ☐ Malignant tumor of prostate
- ☐ Radiation therapy treatment management
- ☐ Transplant of bone a marrow

OTHER:

Past Surgeries

- ☐ None
- ☐ Abdominoperineal resection
- ☐Bilateral replacement of knee joints
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Lumpectomy of breast
- ☐ Lumpectomy of left breast
- ☐ Lumpectomy of right breast
- ☐ Mastectomy of left breast
- ☐ Mastectomy of right breast
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous extraction of kidney stone with fragmentation procedure

- ☐ Excision of squamous cell carcinoma
- ☐ H/O: colostomy
- ☐ H/O: tubal ligation
- ☐ History of appendectomy
- ☐ History of bilateral mastectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of liver excision
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissues graft heart valve replacement
- ☐ History of total cystectomy
- ☐ History of transurethral prostatectomy
- ☐ Hysterectomy
- ☐Hysterectomy-Uterine leiomyoma
- ☐ Kidney biopsy
- ☐ Low anterior resection of rectum
- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Splenectomy
- ☐ Surgical biopsy of skin
- ☐ Total nephrectomy
- ☐ Total orchidectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver

OTHER:

Skin Conditions

- ☐None
- ☐Acne
- ☐ Actinic keratosis
- ☐ Asteatosis cutis
- ☐ Basal cell carcinoma of skin
- ☐ Contact dermatitis due to poison ivy
- ☐ Dysplastic naevus of skin
- ☐ Eczema
- ☐H/O: asthma
- ☐ H/O: allergies
- ☐ Malignant melanoma
- ☐ Pruritus of scalp
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree

OTHER:

Skin Protection

Do you wear sunscreen?☐ Yes ☐No
If yes, what SPF?
Do you tan in a tanning salon?☐ Yes ☐ No

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Family Medical History (ex: mom, dad, brother/sister)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family History of Melanoma

Do you have a family history of Melanoma?☐ Yes ☐ No

If yes:

☐ Mother
☐ Father
☐ Sister
☐ Brother
☐ Daughter
☐Son
☐ Uncle
☐ Aunt
☐ Nephew
☐ Niece
☐ Grandmother
☐ Grandson
☐Granddaughter
☐ Other

Medications (please list all current medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies to Medications

(please list all current medications you are allergic to)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Social History

What is your smoking status?

☐ Unspecified
☐ Unknown
☐ Cigar, smoker
☐ Never smoked
☐Current everyday smoker (tobacco)

☐ **Current someday smoker (cigarettes)**
☐ **Former smoker**
☐ **Heavy tobacco smoker**
☐ **Light tobacco smoker**

Start smoking date:
Number of packs per day:
Quit smoking date:
Total years of smoking:

Alcohol and Drug Use

1. **How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?**
2. **Do you consume alcohol (EtOH or grain alcohol)?☐ Yes☐ No**
3. **Illicit drug use? ☐Yes ☐No**

Sexual Activity

Are you sexually active? ☐ No ☐ Yes, one partner ☐ Yes, multiple partners

Driving Status

☐ Drive in the daytime ☐ Drive at night

Exercise Status

How often do you exercise?
☐ **Unspecified**
☐ **Several times a day**
☐ **Once a day**
☐ **A few times a week**
☐ **A few times a month**
☐ **Never**
☐ **Other**

Caffeine Usage

What is your caffeine use?
☐ **Unspecified**
☐ **Several times a day**
☐ **Once a day**
☐ **A few times a week**
☐ **A few times a month**
☐ **Never**
☐ **Other:**Click or tap here to enter text.

Occupation

What is your occupation and workplace?

Residence Status

Do you feel safe at home? ☐Yes ☐No

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Alerts

☐ **None**
☐ **Allergy to Adhesive**
☐ **Allergy to lidocaine**
☐ **Allergy to topical antibiotics**
☐ **Artificial to heart valve**
☐ **Artificial joint replacement**
☐ **Blood thinners**
☐ **Defibrillator**
☐ **MRSA**
☐ **Pacemaker**
☐ **Require antibiotics prior to a surgical procedure?**
☐ **Rapid heartbeat with epinephrine**
☐ **Are you pregnant of currently trying to get pregnant?**
☐ **Other:**

Thank you for choosing Alamo City Dermatology!