

LAS COLINAS DERMATOLOGY, P.A.

ALISON A. BLACK, M.D.
DERMATOLOGY AND DERMATOLOGIC SURGERY

PATIENT INFORMATION

(ANSWER ALL QUESTIONS • CIRCLE CHOICES THAT APPLY • PRINT CLEARLY)

NAME OF PATIENT _____
LAST FIRST MIDDLE

HOME ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE(____) ____ - ____ DRIVER'S LIC.# _____ SSN _____

CELL PHONE(____) ____ - ____ PREFERRED CONTACT # _____

WORK PHONE(____) ____ - ____ EMPLOYER _____ OCCUPATION _____

SEX M F MARITAL STATUS S M W BIRTHDATE _____ AGE _____ E-MAIL _____

RESPONSIBLE PARTY/INSURED

NAME _____ RELATIONSHIP TO PATIENT _____
LAST FIRST MIDDLE

HOME ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE(____) ____ - ____ EMPLOYER _____ WORK PHONE(____) ____ - ____

SS# _____ DATE OF BIRTH _____

PAYMENT FOR OFFICE VISITS IS EXPECTED AT THE TIME OF SERVICE. HMO/PPO INSURANCE FOR WHICH DR. BLACK IS A PROVIDER WILL BE FILED FOR COVERED SERVICES. YOU ARE RESPONSIBLE FOR REFERRAL APPROVAL FROM YOUR PRIMARY PHYSICIAN IF REQUIRED BY YOUR PLAN, PAYMENT OF COPAYMENTS, CO-INSURANCE, AMOUNTS APPLIED TO YOUR DEDUCTIBLE, AND SERVICES NOT COVERED OR APPROVED BY YOUR INSURANCE COMPANY. SIGN HERE TO AUTHORIZE PAYMENT TO DR. BLACK AND TO AUTHORIZE US TO RELEASE FINDINGS OF OUR EXAMINATION TO YOUR PHYSICIAN OR YOUR INSURANCE COMPANY AS NECESSARY TO PROCESS YOUR CLAIM.

SIGNATURE _____ DATE _____

INSURANCE INFORMATION

PRIMARY CARRIER _____ PHONE #(____) ____ - ____

ADDRESS _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED'S I.D. # _____ GROUP # _____ CO-PAY OR % _____

LAS COLINAS DERMATOLOGY, P.A.

Name: _____ Age: _____ Date: _____
Referred by: Dr. (Name): _____ Family Member (Name): _____
Friend(Name): _____ Yellow Pages: _____ Radio: _____ TV: _____
Other (Please Specify): _____

Medical History:

In your own words, please state the reason for your visit: _____

How long have you had this problem? _____

Symptoms (how does it bother you?): _____

Please list all medications you are currently taking (including over-the counter medications, herbs, vitamins and any other supplements): _____

Please list all drug allergies and the type of reaction you experienced (for example rash, hives, throat swelling, nausea) list reaction to each one: _____

Please list any environmental allergies: _____

Review of Systems:

Have you seen a doctor for other skin problems? ___ Which problems? _____

Have you had any skin, mucous membrane, hair, or nail symptoms not listed above? _____

Women: are you pregnant or do you plan to become pregnant soon? _____

Have you had any of the following?

	Yes	No		Yes	No
1) Pacemaker	___	___	10) Thyroid disease	___	___
2) Heart disease	___	___	11) Anemia	___	___
3) Mitral valve prolapse	___	___	12) Eye disease	___	___
4) Immune deficiency	___	___	13) Tuberculosis	___	___
5) Lung disease	___	___	14) Cancer	___	___
6) Liver disease	___	___	15) High blood pressure	___	___
7) x-ray therapy to skin	___	___	16) Gastrointestinal	___	___
8) Diabetes	___	___	Disease	___	___
9) Epilepsy/Seizures	___	___	17) Blood Clots	___	___
			18) Kidney Disease	___	___

Comments on the above: _____

Past Medical History:

Please list all past major illnesses and operations: _____

Is there a family history of (please circle): melanoma, skin cancer, asthma, hay fever, eczema, psoriasis, hair loss, diabetes, adult acne, genetic diseases? Other: _____

Occupation: _____ Do you use any controlled substances? _____
Do you smoke? _____ Drink alcohol? _____ How Often? _____

When you are exposed to sunlight, do you:

1. ___ always burn 3. ___ often burn, tan slowly 5. ___ rarely burn, always tan
2. ___ usually burn, rarely tan 4. ___ sometimes burn, tan well 6. ___ never burn, deeply tan

LAS COLINAS DERMATOLOGY, P.A.

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Las Colinas Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Las Colinas Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Las Colinas Dermatology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Las Colinas Dermatology Privacy Officer at 440 W. IH 635, Suite 365 Irving, TX 75063.

With my consent, Las Colinas Dermatology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. I understand that Las Colinas Dermatology may occasionally be offering special promotions, events, discounts, or the announcement of new cosmetic treatments, services, or products that I may find of interest.

With my consent, Las Colinas Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards , patient statements and/or information regarding special promotions, events, discounts, or the announcement of new cosmetic treatments, services, or products that I may find of interest.

With my consent, Las Colinas Dermatology may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Las Colinas Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Las Colinas Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Las Colinas Dermatology may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

Las Colinas Dermatology, P.A.

Alison A. Black, M.D.

Dermatology and Dermatologic Surgery

WELCOME TO LAS COLINAS DERMATOLOGY. AS A COURTESY TO OUR PATIENTS WE ARE PROVIDERS FOR AND FILE INSURANCE FOR SEVERAL PPO PLANS. EVERY PATIENT'S INSURANCE PLAN IS DIFFERENT, AND YOUR INSURANCE PLAN BOOKLET SHOULD EXPLAIN THE DETAILS OF YOUR PLAN. HOWEVER THESE ARE SOME GENERAL RULES THAT MOST OF OUR PATIENTS' PLANS FOLLOW: MOST OF THE PLANS PAY 100% OF THE OFFICE VISIT MINUS YOUR COPAY. IF DR. BLACK REMOVES SKIN TAGS, DOES A SKIN BIOPSY, FREEZES IRRITATED KERATOSES OR PRE CANCERS, OR PERFORMS ANY OTHER SURGICAL PROCEDURES YOUR INSURANCE COMPANY MAY APPLY ANY OF THESE CHARGES TO YOUR CALENDAR YEAR DEDUCTIBLE. YOU WILL BE RESPONSIBLE FOR THESE FEES AT THE TIME OF SERVICE IF YOUR DEDUCTIBLE HAS NOT BEEN SATISFIED. IF YOU HAVE QUESTIONS REGARDING THE COST OF ANY TREATMENT PLEASE DO NOT HESITATE TO ASK A STAFF MEMBER OR DR. BLACK PRIOR TO RECEIVING TREATMENT. THANK YOU AND WE LOOK FORWARD TO CARING FOR YOU IN OUR PRACTICE.

PLEASE INITIAL