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	
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			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 Company:	Policy/ID #:	Group #:
Policy Holder's Name:	Policy Holders D.O.B.:	Patient's Relationship to Insured:
Secondary Insurance:	Policy/ID #:	Group #:
Policy Holder's Name:	Policy Holders 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 may 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	□ Colon Cancer	□ Hearing Loss	□ Lung Cancer
□ Arthritis	□ COPD	□ Hepatitis □ A □ B □ C	□ Lymphoma
□ Asthma	□ Coronary Artery Disease	□ High Blood Pressure	□ Prostate Cancer
□ Atrial Fibrillation	□ Depression	□ HIV/AIDS	□ Radiation Treatment
□ Bone Marrow Transplant	□ Diabetes	□ High Cholesterol	□ Seizures
□ BPH (Enlarged Prostate)	□ End Stage Renal Disease	□ Hyper- □ Hypo-thyroidism	□ Stroke
□ Breast Cancer	□ GERD	□ Leukemia	□ **NONE**

Females Only:
□ Number of Pregnancies/Children_____/_____ □ Other_____

Past Surgical History:

□ Appendix	□ Gallbladder	□ Kidney	□ Prostate
□ Bladder	□ Heart: □ Valve □ Bypass	□ Liver	□ Spleen
□ Breast	□ Transplant □ Stent	□ Ovary	□ Uterus
□ Colon	□ Joint: □ Knee □ Hip Year_____	□ Pancreas	□ Other_____

Skin Disease History:

□ Acne	□ Blistering Sunburns	□ Hay Fever/Allergies	□ Psoriasis
□ Actinic Keratoses	□ Dry Skin	□ Melanoma	□ Squamous Cell Carcinoma
□ Asthma	□ Eczema	□ Poison Ivy	
□ Basal Cell Carcinoma	□ Flaking or Itchy Scalp	□ Precancerous Moles	□ Other_____

□ Family History of Melanoma? Who?_____ □ Family History of Skin Cancer? Who?_____

Current Medications, Vitamins, and Supplements: □ **See List**

_____ _____ _____

_____ _____ _____

_____ _____ _____

I am **ALLERGIC** 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: _____

Alerts: (Check all that apply)

□ Active Pregnancy/Breastfeeding	□ Artificial Heart Valve
□ Allergy to Adhesive	□ Artificial Joints < 2 yrs old
□ Allergy to Latex	□ Need Antibiotics prior to procedures
□ Pacemaker	□ Immunosuppression
□ Defibrillator	□ Organ Transplant
□ Brain Stimulator	□ HIV or Hepatitis C

Vaccinations:
□ I have had a flu shot within the past 12 months

□ I have had a pneumonia shot in the past 5 years

Leg Vein Screen:
Do you have:
□ Leg Pain/Aching
□ Cramping/Night Cramps
□ Leg Itching
□ Leg Swelling
□ Leg Rashes

Cosmetics: Check any you have interest in: □ Botox/Dysport □ Fillers □ Treatment for Wrinkling □ Chemical Peels □ Skin Care □ Treatment for Red/Brown Spots