NEW / UPDATED PATIENT INFORMATION

Last Name: _____
First Name: _____
Preferred Name: _____
Middle Name: _____ Suffix: _____
Former Last Name: _____
Gender: _____
Date of Birth: _____ / _____ / _____
Address: _____
Address: *(Apt., Unit, etc.)*: _____
Zip Code: _____
City: _____ State: _____

I wish to be contacted in the following manner:
☐ Home Phone: (_____)_____
☐ Mobile Phone: (____)_____
☐ Work Phone: (_____)_____
Extension: _____

Primary Insurance
Insurance Company: _____
Patient's relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Other _____
Policy Holder Last Name: _____
Policy Holder First Name: _____
Policy Holder Date of Birth: _____ / _____ / _____
Policy Holder Gender: _____

Secondary Insurance
Insurance Company: _____
Patient's relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Other _____
Policy Holder Last Name: _____
Policy Holder First Name: _____
Policy Holder Date of Birth: _____ / _____ / _____
Policy Holder Gender: _____

Have you specifically authorized anyone to make healthcare decisions for you should you become Incompetent and unable to make those decisions yourself? _____Yes _____No

If yes: Name: _____ Telephone Number: _____ Relationship to the Patient: _____

If yes: Name: _____ Telephone Number: _____ Relationship to the Patient: _____

Have you created a ***written*** Power of Attorney for purposes or your healthcare? _____Yes _____No
If yes, please provide a copy of that document(s) to our practice at your earliest convenience.

NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO USE ANO DISCLOSE HEALTH INFORMATION

1. Cibolo Creek Dermatology Group has made the Notice of Privacy Practices available to me.

2. Cibolo Creek Dermatology Group may access, collect, use and disclose my health information to my primary care or referring physician, to consultants, and as necessary to others to process insurance claims, insurance applications and prescriptions.

3. Cibolo Creek Dermatology Group may also disclose my health information these persons:

Name: _____ Phone:(_____) _____ Relationship to the Patient:_____

Name: _____ Phone:(_____) _____ Relationship to the Patient:_____

4. This authorization is effective for all of my records, including past records, and remains in effect until it is revoked in writing, unless date is specified here:

5. Cibolo Creek Dermatology Group may provide me with information on activities and developments, and may disclose my information to third parties who help Cibolo Creek Dermatology Group to inform me. This authorization expires 3 years after my last appointment.

6. I may revoke this authorization, in writing, at any time. This would not be effective to the extent that anyone has already relied on it, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. My treatment, payment, enrollment, or eligibility for benefits is not to be conditioned on this authorization.

Patient's Preferred Phone#: Patient's Email Address:	When contacting me (please check one): ☐ Leave a message with detailed information. ☐ Leave a message with a call back number only. ☐ Do NOT leave a message.

Name of Patient's Primary Care Provider (Primary Medical Doctor):

If possible, please provide this person's Phone # and Fax #:

Pharmacy Name:_____ Phone:(_____) _____

Street: _____

City: _____ State:_____ Zip Code: _____

TODAY'S CHIEF CONCERNS:

Please list the specific skin concerns or questions you would like addressed today:

1)

2)

3)

PAST MEDICAL HISTORY:

Which of the following medical conditions or treatments have you ever had? *Check all that apply.*

☐ HIV/AIDS ☐ Hepatitis B ☐ Hepatitis C ☐ Diabetes ☐ Tuberculosis

☐ Biologic Therapy/ Chemotherapy ☐ Organ or Bone Marrow Transplantation ☐ Radiation Treatment ☐ Cancer (If YES, which types:)

Please list any other known medical conditions, surgeries, and hospitalizations:

Patient/Legal Guardian's Signature:	*(Office use only)* Entered into EMA by:

SKIN CONDITION HISTORY:
Have you ever been diagnosed with or treated for Melanoma? ☐ YES ☐ NO

If YES, please provide more detail:

Have you ever had any of the following skin conditions?

☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Sebaceous Cell Carcinoma ☐ Merkel Cell
☐ Anglosarcoma ☐ Blistering Sunburns ☐ Eczema ☐ Carcinoma Psoriasis

FAMILY HISTORY OF MELANOMA:

Have any of your "first degree relatives" (parent, brother, sister, or child) ever been diagnosed with Melanoma? ☐ YES ☐ NO

If YES, which relatives:

MEDICATIONS:

Please list any current prescription and "over-the-counter" medications **AND** any alternative or complementary therapies **AND** supplements that you use or take. Please include the name of the product, how much, and how often you use or take it. Use the back of this sheet to continue if necessary.

MEDICATION #1	How much (dose)?	How often (frequency)?
MEDICATION #2	How much (dose)?	How often (frequency)?
MEDICATION #3	How much (dose)?	How often (frequency)?
MEDICATION #4	How much (dose)?	How often (frequency)?
MEDICATION #5	How much (dose)?	How often (frequency)?
MEDICATION #6	How much (dose)?	How often (frequency)?
MEDICATION #7	How much (dose)?	How often (frequency)?
MEDICATION #8	How much (dose)?	How often (frequency)?
MEDICATION #9	How much (dose)?	How often (frequency)?
MEDICATION #10	How much (dose)?	How often (frequency)?

Patient/Legal Guardian's Signature:	*(Office use only)* Entered into EMA by:

ALLERGIES:

Do you have any known allergies (including medications, foods, latex, bandage tape)? ☐ YES ☐ NO

If YES, please provide more detail:

SOCIAL HISTORY:

What is your current Smoking Status? ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker

QUALITY MEASURES:

1) Have you ever received a Pneumonia vaccination? ☐ YES ☐ NO

2) Do you have a health care proxy ln the event you are unable to make your own medical decisions) ? ☐ YES ☐ NO

If YES, provide the Designee's name:

If YES, provide the Designee's phone number:

3) Do you have a Living Will (Advanced Care Plan) ? ☐ YES ☐ NO

If you are a **FEMALE** patient *(otherwise leave blank)...*

Are you pregnant or trying to become pregnant? ☐ YES ☐ NO

Are you nursing or breastfeeding? ☐ YES ☐ NO

Patient/Legal Guardian's Signature:	*(Office use only)* Entered into EMA by:

 Date _____ AFFIX PATIENT LABEL HERE

ALERTS:

1) Have you had a flu vaccination (shot or intranasal spray) in the past year? ☐ YES ☐ NO
2) Have you traveled outside of the continental United States in the past 3 months? ☐ YES ☐ NO
3) Do you currently have a pacemaker? ☐ YES ☐ NO
4) Do you currently have a defibrillator? ☐ YES ☐ NO
5) Do you have any artificial heart valves, joints, plates, screws, rods, stents, pins, etc.? ☐ YES ☐ NO

   If YES, were any placed within the last 2 years? ☐ YES ☐ NO
6) Do you require any medications prior to a surgical procedure? ☐ YES ☐ NO

   If YES, for which procedures?

   If YES, what medications do you require?
7) Are you taking any medications that cause you to bleed more easily ("blood thinners")? ☐ YES ☐ NO
8) Have you ever experienced a rapid heartbeat with epinephrine? ☐ YES ☐ NO
9) Have you ever been treated with "gold" (gold sodium thiomalate) therapy? ☐ YES ☐ NO

FAMILY HISTORY

Do any of your "first degree relatives" (parent, brother, sister, or child) have any of the following conditions? *Check all that apply.*

☐ Eczema	☐ Asthma	☐ Hay Fever/ Seasonal Allergies	☐ Psoriasis	☐ Arthritis
☐ Thyroid Problems	☐ Lupus/Connective Tissue Disease	☐ Diabetes	☐ Stroke	☐ Blood Clots
☐ Crohn's/ Ulcerative Colitis	☐ Vitiligo	☐ Scarring/ Keloids	☐ Severe Acne	☐ Pancreatic Cancer

☐ Skin Cancer: If YES, please provide more detail:

Patient/Legal Guardian's Signature:	*(Office use only)* Entered into EMA by: