DALLAS Skin Cancer Center

411 N. Washington Ave, Suite 1200, Dallas, TX, 75246 P: 214-396-5227 F: 214-396-5445

DEMOGRAPHICS

Referring Physician:	Primary Care Provider:		
PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	Age:
Home Street Address:	City:	State:	Zip Code:
Phone Numbers: (please check primary contact number) ☐ Home: ☐ Mobile: ☐ Work:			Date of Birth:
Email Address:	Sex: ☐ Male ☐ Female	Ethnicity:	
S.S. #: (for VA and Medicare only)	Preferred Language:	Occupation: If retired, former occupation?	
Preferred Method of Contact: ☐ Home phone ☐ Mobile phone ☐ Email ☐ Other:			
May we leave a message regarding your protected health information through (CHECK ALL THAT APPLY): ☐ Voicemail ☐ Email ☐ Phone text ☐ Authorized person ☐ No, do not leave a message **Disclaimer:** Our office sends phone call and text appointment reminders.			
EMERGENCY CONTACT			
Name:		Relationship to Patient:	
Home Phone Number:	Mobile Phone Number:	Work Phone Number:	
INSURANCE (please provide insurance cards and ID at check-in)			
Primary Insurance and ID#: ☐ Self-pay		Secondary Insurance and ID# (if applicable):	
FINANCIAL POLICY			
I hereby assign my insurance benefits to be paid directly to Dallas Skin Cancer Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as the original. I understand that all copays, deductibles, and payments for non-covered surgical procedures are due and payable at the time service is provided. I understand that I am financially responsible for all professional fees regardless of insurance coverage. I authorize Dallas Skin Cancer Center to release any information required to process my insurance claims. I have read, understand, and agree to this financial policy.			
Patient Signature (or Legal Representative):		Date:	
PHARMACY INFORMATION			
Pharmacy Name and Address:		Phone Number:	

MRN_____ Date_____ (for clinic use only) **OVER→**

MEDICAL HISTORY

MEDICAL CONDITIONS (Check all that apply): ☐ None

- ☐ Artificial heart valve
- ☐ Artificial joints: _____year of most recent
- ☐ Vascular shunts
- ☐ Rheumatic heart disease
- ☐ Cardiac stents: _____year of most recent
- ☐ Pacemaker / defibrillator
- ☐ Bleeding problems
- ☐ Keloids
- ☐ HIV / AIDS
- ☐ Hepatitis ☐A ☐B ☐C
- ☐ Organ transplant: Type:_____ Year:_____
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Diabetes
- ☐ Heart defect
- ☐ Endocarditis
- ☐ Atrial fibrillation
- ☐ Staph infection
- ☐ High blood pressure
- ☐ Previous skin cancer
- ☐ Mohs surgery
- ☐ Problems healing Explain:_____
- ☐ Seizures

FAMILY HISTORY (include only 1st degree relatives - parents, siblings, children) ☐ None

☐ Melanoma	Please specify which relative(s):

CURRENT MEDICATIONS (Check all that apply): ☐ None

- ☐ Aspirin
- ☐ Plavix/ clopidogrel
- ☐ Coumadin / warfarin
- ☐ Pradaxa / dabigatran
- ☐ Xarelto / rivaroxaban
- ☐ Aggrenox
- ☐ Brilinta / ticagrelor
- ☐ Eliquis / apixaban
- ☐ Other blood thinners
- ☐ Herbal supplements
- ☐ Vitamin E
- ☐ Steroids / Prednisone
- ☐ Fish or Flaxseed oil

Please list all other medications (prescribed and over-the-counter). Attach separate sheet if needed:

_____

_____

_____

_____

Medication allergies and type of reaction: ☐ None ☐ Latex

SOCIAL HISTORY

Do you currently smoke or use tobacco? ☐ No ☐ Yes: _____# packs per day

Is there anything you want your doctor to know that may affect treatment or recovery?

_____

MRN_____ Date_____ (for clinic use only) **OVER ⟶**