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	Initials
I hereby assign my health insurance benefits to be paid directly to Dallas Skin Cancer Center (DSCC). 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 authorize DSCC to release any information required to file my insurance claim. However, all copays, deductibles, coinsurance, and payments for non-covered services are due and payable at the time services are provided. I will notify DSCC in advance if I cannot pay the full amount when it is due. There is a $35 service fee on all returned checks.	
I am responsible for understanding my insurance benefits and to obtain any referrals or prior authorization as required.	
I agree to allow DSCC (or any of its providers) to file an appeal on my behalf if my insurance claim is denied. I agree to assist DSCC in resolving any payment disputes.	
My insurance makes the final determination of eligibility and benefits, and there is no guarantee of insurance payment. I am financially responsible for all non-covered services.	

MRN_____ Date_____ (for clinic use only)

CANCELLATION / NO SHOW POLICY	Initials
Patients are requested to cancel at least 2 business days in advance of their appointment to avoid creating an unused slot that could have been used for another patient. The practice may elect to terminate the patient-provider relationship if there is a history of several no-show occurrences or cancellations less than 1 business day.	
Patients who do not show up or cancel within 1 business day of a *surgery* appointment may reschedule one time before being charged a $100 non-refundable fee to reschedule.	

HIPAA NOTICE OF PRIVACY PRACTICES	Initials
I may request a copy of Dallas Skin Cancer Center's (DSCC) Patient Notice of Privacy Practices.	
It is DSCC's policy to restrict access to my Protected Health Information (PHI) except to communicate with other health care professionals participating in my care and my insurance company for services provided.	
It may become necessary to disclose my PHI to another entity as part of DSCC's treatment, payment, and healthcare operations, and I consent to such disclosure for these permitted uses, including disclosures via fax.	

AUTHORIZATION TO DISCLOSE PRIVATE HEALTH INFORMATION

Besides my health care providers, I would like the following person(s) to have access to my Private Health Information:	Date of birth (for identification only)
_____	_____
_____	_____
_____	_____
☐ None	

I wish to have the following restrictions to the use or disclosure of my health information:
I understand that DSCC is not required to agree to the restrictions requested, and I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

☐ None

I have read, understand, and agree to Dallas Skin Cancer Center's policies:

Patient Name	**Name of Legal Representative (if applicable)**

Signature of Patient (or Legal Representative)	**Date:**

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MEDICAL HISTORY

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth:

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
- ☐ Stroke / TIA
- ☐ 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

PHARMACY

Pharmacy Name and Address:	Phone Number:

SOCIAL HISTORY

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

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

_____

MRN_____ Date_____ (for clinic use only)