TEXAS DERMATOLOGY & SKIN CANCER CENTER

6751 Horizon Road
Heath, Texas 75032
Phone: 469-757-4410 Fax: 469-277-3911

Avani Bhambri, M.D., F.A.A.D. Sanjay Bhambri, D.O., F.A.C.M.S., F.A.A.D., F.A.O.C.D.

# NEW PATIENT REGISTRATION FORM

***Please Print***

**Personal Information** Today's Date: _____/_____/_____

Name *(First, Middle, Last)*: _____

Street Address: _____ City: _____State: _____ Zip Code: _____

Social Security #: _____ - _____ - _____ Age: _____ Date of Birth: _____/_____/_____

Gender *(circle one)*: Male / Female Race: _____ Ethnicity: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Preferred Contact Phone *(circle one)*: Home / Work / Cell / Other (_____) _____ - _____

E-mail: _____

Marital Status *(circle one)*: Single / Married / Other _____ Spouse Name: _____

**Emergency Contact**

Name: _____Phone: (_____) _____ - _____ Relationship: _____

**Employer Information**

Employer Name: _____

Employer Address: _____ Employer Phone: (_____) _____ - _____

**Primary Care Physician**

Name: _____

Address: _____ Phone: (_____) _____ - _____

**Referral Source (How did you find us?)**

Name: _____

(*Circle one*) Doctor/ PCP/Patient / Magazine/ Newspaper /Radio / TV /Unknown /Website/ Word of Mouth

**Insurance Information**

***Primary* Insurance** Name: _____

Name of Insured Party *(First, Middle, Last)*: _____

Date of Birth of Insured Party: _____/_____/_____ Social Security # of Insured Party: _____ - _____ - _____

Relationship to Patient: *(Circle one)* Self / Spouse / Father / Mother / Other _____

Insurance ID #: _____ Group #: _____

Employer/Group Name: _____ Co-Payment Amount: $_____

Amount of Deductible: $_____ Has Deductible Been Met? *(circle one)*: Yes / No

***If insured party is different from the patient, please complete information below:***

Insured Party Home Phone: (_____)_____ - _____ Insured Party Work Phone: (_____)_____ - _____

Insured Party Cell Phone: (_____)_____ - _____

Insured Party Address: _____

Insured Party E-mail: _____

**Secondary Insurance**: Do you have secondary insurance *(circle one)*: Yes / No

If you answered "Yes" please provide details below:

***Secondary* Insurance** Name: _____

Name of Insured Party *(First, Middle, Last)*: _____

Date of Birth of Insured Party: _____/_____/_____ Social Security # of Insured Party: _____ - _____ - _____

Relationship to Patient: *(Circle one)* Self / Spouse / Father / Mother / Other _____

Insurance ID #: _____ Group #: _____

Employer/Group Name: _____ Co-Payment Amount: $_____

Amount of Deductible: $_____ Has Deductible Been Met? *(circle one)*: Yes / No

**If insured party is different from the patient, please complete information below:**

Insured Party Home Phone: (_____)_____ - _____ Insured Party Work Phone: (_____)_____ - _____

Insured Party Cell Phone: (_____)_____ - _____

Insured Party Address: _____

Insured Party E-mail: _____

## *Please read the following statement carefully and sign below:*

All of the information that I have provided on this form is true and complete. The signature below will also be used as a "signature on file" for insurance purposes including any medical information necessary to process relevant claims. I give my permission for photographs to be taken for diagnostic purposes and to enhance medical records and I agree that these photographs may be used for medical, scientific, or educational purposes provided that they do not include any information or content that could reveal my identity.

I hereby authorize all physicians and staff at Texas Dermatology & Skin Cancer Center, PLLC to administer any treatment or to administer such anesthetics and to perform such procedures as may be deemed necessary or advisable for my diagnosis and treatment. **I understand there are no refunds of any kind on any products purchased or services rendered.**

I hereby assign my insurance benefits to be paid directly to Texas Dermatology & Skin Cancer Center, PLLC. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims.

**I certify that the insurance information I have provided above is accurate and that the coverage I have listed above is currently active and not expired. I have read the Texas Dermatology & Skin Cancer Center, PLLC Financial Policy Statement and agree that I am ultimately responsible for all non-covered services.**

**Printed Name** *(First, Middle, Last)*: _____

**Signature:** _____ **Date:** _____/_____/_____

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# NEW PATIENT HISTORY FORM

## Dermatologic Medical History

**Patient Name:** _____ **Date of Birth:** _____ **Today's Date:** _____

Reason for today's visit: _____

Height: _____ Weight: _____ Year of Last Immunization: Flu Vaccine: _____ Pneumococcal Vaccine: _____

**Allergic Reactions** (medications, adhesive tape, lidocaine, latex, food, environmental etc.): Yes / No
If yes, please specify what you are allergic to and what kind of reaction you have:

_____

List **ALL** current medications (including over-the-counter preparations, vitamins, and herbal supplements):

_____

_____

_____

_____

*For **Female** Patients*
□ Currently pregnant *(if checked, please specify due date)*: _____/_____/_____ □ Currently breastfeeding
□ Currently on birth control *(if checked, please specify type)*: _____

## *Social History*

Marital Status: Single / Married / Divorced / Widowed / Other:_____ Hobbies: _____
Level of Education: High School / Bachelor's / Graduate / Post-Graduate / Other:_____
Occupation (if retired, please list your past occupation): _____
Currently Employed: Yes / No. If yes, Where: _____

Do you smoke / consume alcohol or recreational or illicit drugs: Yes / No
If yes, please specify type and quantity:
□ Smoking □ Alcohol □ Recreational/Illicit Drugs □ Chewing Tobacco Quantity: _____
Prior or current sexually transmitted disease: Yes / No If yes, please specify type: _____

***Family History***

Current Health Status of your family members (if not alive, please list cause and age of death):

Mother: _____ Father: _____ Siblings: _____ Children(s): _____

***Medical History***

Please list any **prior** operations that you have had:

_____

_____

Please list any **prior** major illnesses and injuries that you have had:

_____

_____

Please list any **prior** hospitalization (s) that you have had:

_____

Do you have a history of an infectious disease such as Hepatitis B, Hepatitis C, and/or HIV/AIDS: Yes / No

If Yes, Please List_____

**Do you have any of the following? *(please circle all that apply)*:**

| Yes | No | | |
|---|---|---|---|
| □ | □ | **General** | Fatigue, sudden change in weight (loss/gain), fevers/chills, night sweats |
| □ | □ | **Cardiac** | Heart disease, high blood pressure, pacemaker, defibrillator, heart murmur, irregular heartbeat, chest pain, fainting |
| □ | □ | **Vascular** | Leg swelling/pain, vein inflammation/phlebitis, deep vein thrombosis (DVT) |
| □ | □ | **Pulmonary** | Asthma, chronic cough, wheezing, emphysema, sleep disturbances due to breathing |
| □ | □ | **Gastrointestinal** | Change in appetite, heartburn, nausea/vomiting, abdominal pain, change in bowel habits |
| □ | □ | **Endocrine** | Diabetes, thyroid disease (hyperthyroidism or hypothyroidism), polycystic ovarian syndrome |
| □ | □ | **Genitourinary** | Kidney disease, frequent urination, genital rash or sores |
| □ | □ | **Rheumatologic** | Lupus, rheumatoid arthritis, dermatomyositis, polymyositis, other autoimmune disease *(please specify)*: _____ |
| □ | □ | **Hematologic** | Hemophilia, anemia, other bleeding disorder *(please specify)*: _____ |
| □ | □ | **Allergic** | Seasonal allergies, hives, eye irritation, changes in vision, frequent colds, nosebleeds, bleeding gums |
| □ | □ | **Psychiatric** | Mood disorder, depression, memory changes, thoughts of suicide or violence |
| □ | □ | **Neurologic** | Convulsions/seizures, headaches, tremors, weakness/numbness, paralysis |
| □ | □ | **Musculoskeletal** | Arthritis, joint pain or stiffness, artificial (prosthetic) joint, muscle weakness |
| □ | □ | **Infectious** | HIV/AIDS, hepatitis *(type)* _____, blood transfusion, cold sores/herpes |

**Dermatologic:**

Please list any **prior** cosmetic procedures that you have had:

_____

_____

**Personal history of atypical (abnormal) moles or skin cancer** *(circle all that apply)*:
Atypical (abnormal) Mole(s): Yes / No  If yes, please list location of the mole: _____

**Skin Cancer:** Melanoma / Squamous Cell Carcinoma / Basal Cell Carcinoma / Not Sure of the Type / Other: _____
Year of Diagnosis: _____ How was it treated: _____

**Family history of atypical (abnormal) moles or skin cancer** *(circle all that apply)*:
Atypical (abnormal) Mole(s): Yes / No

**Skin Cancer:** Melanoma / Squamous Cell Carcinoma / Basal Cell Carcinoma / Not Sure of the Type / Other: _____
Who in your family was diagnosed with skin cancer: _____

Please list the **Pharmacy (including Location)** that you use for your prescriptions:

_____

**Patient's Printed Name** (First, Middle, Last): _____
**Signature**: _____
**Date**: _____/_____/_____

**Medical Staff Reviewer's Printed Name** (First, Middle, Last): _____
**Signature**: _____
**Date**: _____/_____/____

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# FINANCIAL DISCLOSURE POLICY

Thank you for choosing Texas Dermatology & Skin Cancer Center, PLLC for your dermatologic care. In order to minimize confusion and misunderstanding between our patients and the practice, we have adopted the following financial policies. If you have any questions about our policies, please discuss them with one of our staff members.

We are dedicated to providing you with the best possible care and service and we regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

## General

Your insurance policy is a contract between you and your insurance company only. If you fail to notify our practice of any insurance change(s), you are fully responsible for any amount not paid by your insurance company. Each health plan varies with regard to deductibles, co-payments, and co-insurance. Terms are contracted between the insurance company and the patient at the time you accept the insurance. It is your responsibility to be aware of your deductibles, co-payments, and co-insurance, and it will be your obligation to remit all appropriate payments as outlined in your insurance policy.

**Insurance policy requirements do not allow our practice to absorb any co-payments, coinsurance, or deductibles.**

**All deductibles, co-payments, and co-insurance are due at the time of service.**

**NO Refunds are provided on ANY services rendered and/or products purchased.**

## HMO / PPO / Other Insurance Coverage

If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a current/valid driver's license. All co-payments are due prior to seeing the physician on the day of visit. If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will responsible for all deductibles, co-insurance, co-payments, and any services denied by your insurance carrier as not medically necessary and/or not covered.

## Medicare

Our physicians are participating Medicare providers and accept Medicare assignment as of June 2011, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy, we will submit any remaining balance to that particular carrier. You will be responsible for all deductibles, co-insurance, copayments, and any services denied by your insurance carrier as not medically necessary and/or not covered.

**Laboratory**
Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

**Self-Pay Patients**
For patients with no insurance, the guarantor is responsible for the bill at the time of service.

**Cosmetic Patients**
Cosmetic procedures will not be submitted to your insurance company. Payment is due at the time of service.

**Minor Patients**
For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred during the visit.

**Payments**
Payments can be made by cash, check, VISA, or MasterCard. Patient balances are due immediately upon receipt of statement. NO refunds of ANY kind are provided.

**Returned Checks and Collections**
A charge of $35 will be applied for all returned checks. In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services rendered at Texas Dermatology & Skin Cancer Center, PLLC

**No Show Fee**
We understand that you may have to cancel your appointment. We ask that you kindly give us 24 hour notice. In an event you fail to notify us, Texas Dermatology and Skin Cancer Center, PLLC will charge you a fee of $35.

**I have read and fully understand ALL of the information listed above.**

**Printed Name** (First, Middle, Last): _____

**Signature**: _____

**Date**: _____/_____/_____

**Benefits Assignment**

I hereby authorize the assignment of benefits (payments) directly to Texas Dermatology & Skin Cancer Center, PLLC / Avani Bhambri MD / Sanjay Bhambri DO for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-payments, deductibles, and non-covered services are due in full at the time of service.

**Signature of Responsible Party**: _____ **Date**: _____/_____/_____

**Records Release**

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

**Signature of Responsible Party**: _____ **Date**: _____/_____/___

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# NOTICE OF PRIVACY PRACTICES

## WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have been offered a copy of

the Texas Dermatology and Skin Cancer Center, PLLC's Notice of Privacy Practices.

If you need a written privacy practice notice please ask us.

**Signature:** _____ **Date:** _____

### Disclosure Statement

We intend to use and disclose PHI (Protected Health Information) in the following ways:

1) To contact you or leave messages for you regarding appointments;
2) To provide alternate treatment information;
3) To contact you or leave messages for you regarding test results;

By signing below you give us your permission to use and disclose your PHI in the above stated manner.

Please list the names and phone numbers, in preferential order, of the people we may contact:

1. _____
2. _____
3. _____

**Signature:** _____ **Date:** _____