AUSTIN SKIN

medical + surgical + cosmetic dermatology

HISTORY AND INTAKE FORM

Demographics

Full Name:

Nickname:

Parent/Guardian & relationship (if patient is a minor):

Mailing address:

Birthday: DD / MM / YYYY

Email:

Phone # Home:

Cell:

Primary Care Doctor (First and Last Name):

City:

Specialty:

How did you hear about our office?

Emergency Contact

Name:

Phone #:

Relationship:

Do you have Power of Attorney? Y N

☐ Same details as EMERGENCY CONTACT

Name:

Phone #:

Relationship:

Insurance Policy Holder Information

Primary Insurance:

Name of Policy Holder:

Relationship to Policy Holder:

Policy Holder's DOB: DD / MM / YYYY

Do you have secondary insurance? Y N

Do you have prescription Insurance? Y N

If you have secondary or prescription insurance, please provide those cards to the office

Preferred Pharmacy

Name:

Pharmacy Phone #:

Pharmacy City or Zip Code:

Past Medical History (please circle all that apply)

☐ NONE

Anxiety | Arthritis | Asthma | Atrial Fibrillation | Bone Marrow Transplantation | Breast Cancer

Colon Cancer | COPD | Coronary Artery Disease | Depression | Diabetes | End Stage Renal Disease

GERD | Hearing Loss | Hepatitis | High Blood Pressure | HIV/AIDS | High Cholesterol

Thyroid Problems | Leukemia | Lung Cancer | Lymphoma | Prostate Cancer | Radiation Treatment

Seizures | Stroke

Other:

Past Surgical History (please circle all that apply)

☐ NONE

Appendix Removed | Bladder Removed | Gallbladder Removed | Mastectomy Right | Left | Bilateral

Colectomy Reason: Lumpectomy Right | Left | Bilateral

Mechanical Valve Replacement | Coronary Artery Bypass | Breast Implants | Breast Reduction

Biological Valve Replacement | Heart Transplant | Ovaries Removed Reason:

Kidney Biopsy (Nephrectomy) | Kidney Transplant | Hysterectomy Reason:

Kidney Removed Right | Left | Kidney Stone Removal | Prostate Removed: Prostate Cancer

Spleen Removed | Testicles Removed Right | Left | Bilateral | TURP (Prostate Removal)

Joint Replacement, Knee Right | Left | Bilateral Date: DD / MM / YYYY

Joint Replacement, Hip Right | Left | Bilateral Date: DD / MM / YYYY

Other:

Personal History of skin cancer, pre-cancerous lesions and **atypical** (dysplastic) **moles**

☐ NONE

Year(s) and Location

☐ Basal Cell Carcinoma ____________________

☐ Squamous Cell Carcinoma ____________________

☐ Melanoma ____________________

☐ Atypical moles ____________________

Other Skin Disease History (please circle all that apply)

Acne | Actinic Keratoses | Blistering Sunburns | Lupus | Dry Skin | Eczema

Flaking or Itchy Scalp | Hay Fever/Allergies | Poison Ivy | Psoriasis | NONE

Other:

Do you wear Sunscreen? Y N If yes, what SPF?

Do you or have you ever tanned at a tanning salon? Y N

Do you have a history of cold sores? Y N

Do you have a family history of Melanoma? Y N

If yes, which relative(s)?

Review of Systems: Are you currently experiencing any of the following?

Problems with bleeding Y N
Problems with scarring (keloids) Y N
Problems with healing Y N

Rash Y N
Immunosuppression Y N
Hay Fever Y N
Chest pain Y N
Fever or chills Y N

Unintentional weight loss Y N
Thyroid problems Y N
Sore throat Y N
Blurry Vision Y N

Abdominal pain Y N
Headaches Y N
Joint Aches Y N
Bloody stool Y N
Bloody urine Y N

Other symptoms:

Medications (Please list all current medications)

Can attach separate sheet if easier.

#		Dose:	Freq:
1		Dose:	Freq:
2		Dose:	Freq:
3		Dose:	Freq:
4		Dose:	Freq:
5		Dose:	Freq:
6		Dose:	Freq:
7		Dose:	Freq:
8		Dose:	Freq:

Over the Counter Medications

	Dose:	Freq:
1	Dose:	Freq:
2	Dose:	Freq:
3	Dose:	Freq:
4	Dose:	Freq:

Allergies (Please list all allergies)

☐ Check here if no known drug allergies

1	5
2	6
3	7
4	8

Surgical Alerts (please circle all that apply)

☐ NONE

Allergy to Adhesive | Allergy to lidocaine | Allergy to topical antibiotics | Artificial heart valve

Artificial joint replacement | Blood thinners | Defibrillator | MRSA | Pacemaker

Require antibiotics prior to a surgical procedure | Rapid heartbeat with epinephrine

HIV/ AIDS | Hepatitis B | Hepatitis C

Women of Childbearing Age

Are you pregnant? Y N Are you trying to become pregnant? Y N Are you breastfeeding? Y N

Social History

Do you smoke? ☐ Current ☐ Past ☐ Never

If YES Current Smoker ☐ Less than Daily ☐ Daily ______ Packs/day

Women How often in the past year have you had 4 drinks in a day? Y N

Men How often in the past year have you had 5 drinks in a day? Y N

Adults over 65 Flu shot? (October 1- March 31) Y N Pneumonia shot? Y N

Who is filling out this form? ☐ Patient ☐ Other

If Other, please specify relationship to patient:

Signature:

Date: DD / MM / YYYY

Patient name: | Date of Birth: DD / MM / YYYY

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ACKNOWLEDGMENT AND CONSENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Initial

I, [print patient name], have read a copy of Austin Skin's Notice of Privacy Practices. *(This document is available at the front desk)*

RELEASE OF MEDICAL INFORMATION

Initial

In the event that Austin Skin needs to contact you (patient) regarding medical information about an appointment, lab/ biopsy result, medication, or any other reason, it is permissible to release your information:

☐ Okay to Speak with Another Person

Name:	Phone #:
Name:	Phone #:

I understand that I can revoke this consent, in writing, at any time.

I DO NOT authorize Austin Skin to release any medical information to anyone.

Initial

CONTACT METHODS

Initial

I consent to Austin Skin communicating with me in the following ways, understanding that such communication may include the disclosure of protected health information.

☐ Leave a detailed message on voice mail ☐ Text messaging ☐ Email

Austin Skin uses Klara, which is HIPAA compliant and secure software for patient communication via text and voicemail.

I DO NOT authorize Austin Skin to disclose any protected health information other than verbally, through mail, or a HIPAA-compliant patient portal

Initial

PATIENT PORTAL

I DO authorize Austin Skin to publish my benign results to my patient portal.

Initial

I DO NOT authorize Austin Skin to publish my benign results to my patient portal.

Initial

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INSURED FINANCIAL RESPONSIBILITY

Initial

I authorize Austin Skin, to the fullest extent possible, the right to bill and receive payment from any third-party insurance, as well as Medicare, Tricare, or any other Federal or State benefits program, for services provided by Austin Skin. I request that my insurance carrier make payment directly to Austin Skin for services rendered to me. I also authorize and assign the right to Austin Skin to pursue any claim, appeal, right, or cause of action, including any claims that may be brought pursuant to ERISA (including claims for breach of fiduciary duty, declaratory and injunctive relief) and, if necessary, litigation against any ERISA-regulated plan.

While Austin Skin will bill insurance on my behalf, I understand that I am ultimately financially responsible for all charges. All procedures are subject to any applicable copays, deductibles and/or coinsurance.

If my insurance plan requires a referral, I understand that it is my responsibility to ensure that a referral from my primary care doctor is obtained prior to my medical visit(s). I will be financially responsible for charges associated with medical services if the proper referral has not been obtained and if permitted by my insurance contract. If a referral is not obtained prior to your visit, our staff will try their best to inform you and help you reschedule your appointment.

UNINSURED FINANCIAL RESPONSIBILITY

Initial

If you do not have insurance coverage, payment in full is due at the time of your visit unless payment arrangements are made prior to your appointment. Any elective procedure will not be done unless full payment is received at the time of your visit.

My signature below indicates that I have read and agree with all statements initialed above.

Signature of Patient (or guardian):	Date: DD / MM / YYYY

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CANCELLATIONS, LATE CANCELLATION & NO-SHOW POLICY

At Austin Skin, we are committed to providing you with the highest quality of care with the best access to our physicians possible. This means that we block your appointments to allow you to have a personalized and thorough visit. To help patients remember their scheduled appointments, our office will attempt to reach you to confirm your appointment. While we understand that there are valid reasons for canceling or missing an appointment, we ask that you please show consideration by calling in advance should you need to cancel or reschedule. This courtesy will allow us to offer the appointment to another patient.

No-Show/Cancellation Policies

We require at least a **24-hour** notice to cancel or reschedule your appointment. **An appointment canceled within 24 hours of your appointment time is considered a no-show.** Please speak with our office staff if a special circumstance results in the late cancellation of your appointment.

For NEW and ESTABLISHED PATIENTS with INSURANCE, the fee schedule is as follows:

$50	$100	$150	X
will be charged to your credit card on file after your first no-show appointment	will be charged to your credit card on file after your second no-show appointment	will be charged to your credit card on file after your third no-show appointment	After your third no-show appointment, we will terminate you from the practice

For NEW and ESTABLISHED COSMETIC and SELF-PAY PATIENTS, the fee schedule is as follows:

$100	$150	X
will be charged to your credit card on file after your first no-show appointment	will be charged to your credit card on file after your second no-show appointment	After your second no-show appointment, we will terminate you from the practice

Phone Call/Medical Advice Policies

Extensive phone calls and portal messages may incur a **$25** fee, particularly if a new medication is prescribed or a new problem is addressed. Exceptions to this policy include post-procedural concerns and adverse reactions to medications.

Please speak with our office staff if a **special circumstance** results in a no-show or late cancellation of your appointment.

Signature:

Date: DD / MM / YYYY