Baylor Scott & White
DERMATOLOGY SPECIALISTS
MCKINNEY
*A member of HealthTexas Provider Network*

# NEW PATIENT HISTORY

**Last Name**: _____ **First Name**: _____ **M / F**

**Today's Date**: _____ **Birthdate**: _____ **Age:** _____

**Height:** _____ **Weight:** _____

**How did you hear about us? ❒Insurance ❒Physician ❒Friend** _____**❒Other**_____

**Primary care physician:** _____
**Name** **City** **Phone**

**Referring physician:** _____
**Name** **City** **Phone**

**Preferred pharmacy:** _____
**Name** **City** **Phone**

*We wish to address all of your medical, surgical and cosmetic dermatology concerns. Completing the table below begins a record of priorities you wish us to devote attention to now and in the future. Due to new restrictions in many insurance plans, a limited number of items can be evaluated or performed during a visit. For this reason, after a **full assessment** of your concerns today, you and the physician may re-prioritize your list to address the items of upmost medical necessity or well-being first. We look forward to working with you to successfully address all of your dermatologic needs.*

## LIST OF DERMATOLOGIC CONCERNS YOU WANT TO ADDRESS

**List your concerns first and then determine the priority on the far right hand column.**

| | Concern / Body Location | When did you first notice it? | Does anything make it better? | Does anything make it worse? | Mild, moderate or severe? | Signs & symptoms (i.e. itch, burn, sting, none) | What treatments, if any, have you tried? | Priority (1-3) |
|---|---|---|---|---|---|---|---|---|
| A | / | | | | | | | |
| B | / | | | | | | | |

## HAS A PHYSICIAN OFFICIALLY DIAGNOSED YOU WITH ANY OF THE FOLLOWING? (Circle Yes if positive)

| | | | | | |
|---|---|---|---|---|---|
| Y | Abnormal healing scars (Keloids) | Y | Hives | YOUR SURGICAL HISTORY | |
| Y | Antibiotics before surgery | Y | Hyperhidrosis (excessive sweat) | Y | Artificial heart valves |
| Y | Anxiety | Y | Hyperthyroidism | Y | Defibrillator / Pacemaker |
| Y | Arthritis | Y | Hypothyroidism | Y | Hysterectomy (date) |
| Y | Bleeding problems | Y | Kidney Disease | Y | Implants |
| Y | Blistering Skin Condition | Y | Patch Testing | Y | Joint replacement |
| Y | Blood clots (DVT) (date) | Y | Psoriasis | Y | Radiation treatment |
| Y | Dialysis | Y | Spider Veins | Y | Transplant (date) |
| Y | Eczema (Atopic Dermatitis) | Y | Stroke | Y | Other |
| Y | Fibromyalgia | Y | Tuberculosis | | |
| Y | Hay Fever / Allergies | Y | Ulcerative Colitis | | |
| Y | Heart Disease (CHF, etc) | Y | Varicose Veins | | |
| Y | Hepatitis, Type | | | | |
| Y | Herpes - genital or mouth (circle) | FOR FEMALES ONLY: | | FOR MALES ONLY: | |
| Y | High blood pressure | Y | Currently Breast Feeding | Y | Prostate Cancer |
| Y | High cholesterol | Y | Pregnant (due date) | Y | Benign Prostatic Hypertrophy |
| Y | HIV / AIDS | Y | Irregular menses/Menopause | Y | Prostate Cancer |

## NEW PATIENT FORMS

| **YOUR** Skin Cancer History (Actinic Keratosis, Basal Cell, Squamous Cell, Melanoma) | | | |
|---|---|---|---|
| **Indicate type of growth (diagnosis)** | **Location** | **Treatment date** | **Method of treatment** |
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4** | | | |
| **5.** | | | |

**DO YOU HAVE A PARENT OR SIBLING WITH A HISTORY OF MELANOMA? (CIRCLE ONE) YES NO**

Parent: _____ Sibling:

| YOUR SOCIAL HISTORY | | |
|---|---|---|
| **Y** | **N** | **Religious preference?** |
| **Y** | **N** | **Hobbies** |

| | | |
|---|---|---|
| **Y** | **N** | **Smoke tobacco - cigarettes, cigars or pipe (indicate by circling)** |
| **Y** | **N** | **Smoke tobacco - _____ / day for _____ years ❒ Year quit _____** |
| **Y** | **N** | **Chew tobacco - # of cans / day _____ # of years _____ ❒ Year quit _____** |
| **Y** | **N** | **If you don't smoke, does someone smoke in your home?** |

| | | |
|---|---|---|
| **Y** | **N** | **Have you ever had a blistering sunburn?** |
| **Y** | **N** | **Sun exposure ❒ rarely ❒ occasionally ❒ frequently** |
| **Y** | **N** | **Do you wear a daily sunscreen? ❒ 15 ❒ 30 ❒ 45 ❒ 55+ brand_____** |
| **Y** | **N** | **Have you ever used a tanning bed?** |
| | | **If yes, how often have you used a tanning bed? _____(# of total sessions)** |
| | | **If yes, when did you start using a tanning bed? _____(age)** |

| YOUR COSMETIC HISTORY | | | | | |
|---|---|---|---|---|---|
| Y | N | Blepharoplasty (Eyelid lift) | Y | N | IPL (laser for red, brown spots) |
| Y | N | Botox, Dysport (Wrinkles of the face) | Y | N | Fillers - Juvederm, Restylane, other |
| Y | N | Chemical peel | Y | N | Latisse (Eyelash treatment) |
| Y | N | Face lift | Y | N | Microdermabrasion |
| Y | N | Fractional Laser (Laser skin rejuvenation) | Y | N | Sclerotherapy |
| Y | N | Hyperhidrosis Treatments | Y | N | Other: |

## YOUR MEDICATIONS & ALLERGIES

**CIRCLE if you take any of the following:** aspirin vitamin E St. johns wart garlic fish oil

| DERMATOLOGY MEDICATION | DIRECTIONS FOR USE | START DATE | END DATE | REASON FOR CHANGE OR DISCONTINUATION |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| OTHER MEDICATIONS | DIRECTIONS FOR USE | START DATE | END DATE | CONDITION |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| HERBAL, SUPPLEMENTAL & NON-PRESCRIPTION MEDICATIONS | DIRECTIONS FOR USE | START DATE | END DATE | DIAGNOSTIC USE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

❒ NO ALLERGIES ❒ALLERGIES: _____,_____,_____ ❒Adhesive ❒Latex

*If you need additional space, let us know and we will provide an additional sheet.*

# Practice Policies

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement a cancellation and no-show policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

**Initials**

**Cancellation of an Appointment**

_____ In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be relocated to someone who is in urgent need of treatment. We ask that you make an attempt to call 24-48 hours in advance.

**No Show Policy**

_____ A "no show" is a missed appointment that was not canceled in advance with at least a 24 hour notice. No shows inconvenience other patients who need access to medical care. Two "no-show" appointments in a six-month period will result in dismissal from the practice. New patients who do not show for their appointment may not be rescheduled.

**Late Arrivals**

_____ In an effort to serve our patients in a more timely manner, we request that you be on time for your scheduled appointment. In the event you are running late, please be respectful and call ahead. If you are late for your appointment, you may be asked to reschedule.

**Walk-In Patients**

_____ We realize that health conditions often occur unexpectedly. Walk-in care may be provided for urgent dermatologic care. We will do our best to accommodate you at the earliest possible time. Please consider that you may have to wait for an extensive amount of time, as we see other patients as scheduled. We suggest ahead to find out if there is a time we would most likely be able to accommodate you. If the need is not urgent, you will be asked to schedule an appointment. In the case of a walk-in, the provider will address the presenting problem only.

**Insurance Filing and the Law**

_____ Most of the services provided in this office are medically necessary and paid for by your insurance company. Unfortunately, not all services are covered and may be considered elective or cosmetic. In cases where the service has been denied by your insurance, you will be personally responsible for the bill. Federal laws addressing insurance company transactions require that we submit claims to insurance company accurately, reporting the exact services performed and the exact reason for performing them. We are not allowed to alter the medical records or claims forms. Our practice strictly adheres to these laws, and will submit claims to all insurance companies in this manner.

**Secondary Insurance**

Our corporate billing office will file secondary insurance for our patients once, as a courtesy. After 90 days, if your secondary insurance has not paid on a claim, the balance will become patient responsibility.

**Non-Covered Services Are Your Responsibility.**

Medical plans have many unique stipulations. If you are not sure if a service is covered by your plan, you will need to call your insurance company in advance to see what your financial responsibility will be prior to being seen and treated. It is the patient's responsibility to obtain a referral for HMO plans. If you fail to obtain a referral, you will be financially responsible for all charges.

**Understanding Your Financial Obligation**

As a patient, it is in your best interest to know if your plan is contracted with Jonathan Richey, DO and to understand your insurance plan benefits. This includes, but not limited to, understanding your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. You may have different deductibles, co-insurance, or co-payment amounts, depending on the contracted status of your insurance company. **Patients are responsible for all payments including, but not limited to co-pays, co-insurance, deductibles, and past due balances at the time of service.** If your account is past due, it will be turned over to our collection agency. We accept cash, check, debit cards, MasterCard, Visa, American Express, and Money Orders.

**Pathology**

You may receive a separate bill for laboratory or pathology services from an off-site lab for any tests your physician orders. Or you may receive a separate pathology bill from Dr. Richey, as he is also a dermatopathologist and my read your pathology slides himself. In the case you receive a bill from an outside lab; you may discuss any bills with that lab.

It is also important to understand your insurance plan's current benefit and coverage rules. Policies and coverage determinations may vary from year to year. Please be aware that most procedures performed in our office are considered surgical, according to the American Medical Association. This includes excisions, shaves, biopsies, intralesional injections, and destructions by any method. "Any method" includes electrosurgery, cryosurgery, laser and chemical treatment of a lesion. Lesions include molluscum, warts, milia, benign, premalignant, or malignant lesions. **Surgeries are often applied toward patient's deductibles and/or co-insurance.**

Not all services are covered in all insurance contracts. If your insurance plan benefits do not cover a service or procedure, you will be held personally responsible for payment of these charges. To find out what your insurance plan benefit covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source for information and assistance.

# Consent for Photography

Patient Name: _____ Date: _____

I consent for medical photographs to be made of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Baylor Scott and White – Dermatology Specialists, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Baylor Scott and White – Dermatology Specialists at (469) 800-5325.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

**Please sign <u>one</u> of the following:**

1. I **consent** for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes at Baylor Scott and White – Dermatology Specialists and to be used in my medical record.

   Patient Signature _____ Date_____

**For Teaching Purposes ONLY:**

2. I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publication.

   Patient Signature _____ Date_____