OASIS DERMATOLOGY

New Patient Information Record

Patient Information

Name
Last _____ First _____ MI _____

Address
Street _____

_____

City _____ State _____ Zip Code _____

Contact
Home Phone: ( ) __ __ __ - __ __ __ __ Work: ( ) __ __ __ - __ __ __ __
Cell: ( ) __ __ __ - __ __ __ __ Email: _____

Personal Info
Date of Birth (MM/DD/YYYY): _ _ / _ _ / _ _ _ _ Sex: Male __ Female __ SSN _ _ _ - _ _ - _ _ _ _
Race: American Indian__ Asian__ Black__ Pacific Islander__ Other__ Decline to Answer__
Ethnicity: Hispanic__ Non-Hispanic__ Decline to Answer__
Language: English__ Spanish__ Other_____

Emergency Contact

Name: _____
Home Phone: ( ) __ __ __ - __ __ __ __ Cell: ( ) __ __ __ - __ __ __ __

Employment Information

Employer: _____
Status: Not Employed__ Full-Time__ Part-Time__ Retired__ Unknown__
Work Phone: ( ) __ __ __ - __ __ __ __ Extension_____

Insurance Information

	Primary	*Secondary*	*Additional*
Insurance Name			
Policy Holder			
Relationship to Insured			
Policy Number			
Group Number			

Name_____ **Date of Birth**_____ **SuperBill#**_____
Referred By_____

CHECK-IN_____

Reason for visit : _____
Where (location)?_____ **How Long?** _____
Symptoms (CHECK) None___ Itching___ Stinging___ Burning___ Painful___Worsen___ Improve___ Unchange___
Severity: Not noticeable___ Intense___ Moderate___ Mild___
Duration of the symptoms: Present all the time___ Come and Go___ Rarely occurs___
How has it been treated? _____
Other skin condition: _____
Topical (skin) medications already used: _____

System Review Do you have or have you RECENTLY had any of the following? PLEASE CHECK

Const:	____ weight loss	____ weight gain	____ fever	____ chills
Eyes:	____ sudden vision changes		____ loss of vision	
ENT:	____ sores in the mouth or lip		____ blisters the mouth or on the lips	____ hearing loss
CV:	____ palpitation		____ chest pain	
Resp:	____ severe cough		____ shortness of breath	
GI:	____ nausea or vomiting		____ change in bowel (diarrhea/constipation)	
GU:	____ painful urination		____ blood in urine	
M/S:	____ muscles stiffness		____ joint pain	
Skin:	____ masses or lumps on the skin		____ hair or nail changes	
Neuro:	____ memory change	____ vision change	____ vision loss	____ loss of balance

Past Medical History/Inactive Problems:

High Blood Pressure	Yes	No	Anemia	Yes	No	Stomach/Bowel Problem	Yes	No
Heart Disease	Yes	No	HIV infection	Yes	No	Recent Weight Loss	Yes	No
Cardiac Pacemaker	Yes	No	Seizures or epilepsy	Yes	No	Asthma or Lung Problems	Yes	No
Heart Murmur	Yes	No	Radiation Therapy	Yes	No	History of skin cancer	Yes	No
Diabetes	Yes	No	Ultraviolet light treatment	Yes	No	Kidney/Bladder Problem	Yes	No
Liver disease or hepatitis	Yes	No	Cancer	Yes	No	Other:		

Surgical History:

Pacemaker or Defibrillator?	Yes No	If YES, When?_____ and Which?	Pacemaker Defibrillator
Artificial Heart Valve/Heart Stent?	Yes No	If YES, When?_____ and Which?	Heart Valve Stent
Artificial Joints Replacement?	Yes No	If YES, When? _____	
Anticoagulants?	Yes No	If YES, Please circle:	Coumadin Aspirin Plavix Other
Mitral Valve Prolapse or Endocarditis?	Yes No	If YES, When?_____ and Which?	Prolapse Endocarditis
Allergy to Injected Anesthetics?	Yes No	If YES, Which one(s)?_____	

Do you need antibiotics before all surgical or dental procedures? Yes No

Medication: Please List all your current medications _____
_____
_____
_____

Allergy: List any medication allergies _____
_____
_____

Family History: List any family member with History of Skin Cancers or other skin related diseases: _____
_____
_____

Alcohol consumption : No Occasionally Daily
Social History: Please list your occupation
_____

Smoking Status: NEVER____ SOME DAYS____ EVERYDAY____ FORMER(QUIT)____ UNKNOWN ____
Currently Pregnant: ____ or Breastfeeding: ____

PREFERRED PHARMACY:_____

By my signature below, I confirm the above information regarding the medical history and review of systems are correct and up-to-date.

PICTURES TAKEN

X_____ _____
PATIENT SIGNATURE Date

Witnessed by:
_____

____Kevin Burningham MD ____Eric Sandrock DO ____Valeria Gonzalez MD ____Gabriela Ramirez PA-C
____ Kelly Maedo MD ____Sonia Neave MD ____Hervey Galvan PA-C ____Daisy Elizondo PA-C
____Alexis Wood PA-C ____Rick Lin DO REVIEWED BY - HEALTHCARE PROVIDER INITIALS

OASIS DERMATOLOGY

Photography Permit

I hereby authorize the appropriate personnel of the office of Dr. Rick Lin, Dermatologist and/or the Dermatology Clinic of McAllen to take photographic and digital pictures of my skin condition.

I hereby state that it has been fully explained to me that said pictures are taken for the purpose of medical record documentation and for the showing to the duly licensed physicians, and authorized paramedical personnel, for teaching purposes.

I further state that at the time of the execution of the consent, that I am fully aware of the pictures to be taken and the uses, as above described, to which the are to put, and that all questions with respect to the taking of the pictures and the use thereof have been fully explained to me and to my complete satisfaction by personnel of the Dermatology Clinic of McAllen.

_____ _____

Signature **Date**

OASIS DERMATOLOGY

Patient Consent For Use and Disclosure of Protected Health Information

The following Individuals are authorized to receive my healthcare information regarding medical records, appointments and/or any other information Oasis Dermatology has in its medical records regarding treatment, diagnosis, labs or pathology reports.

	NAME	**RELATIONSHIP**
1.	_____	_____
2.	_____	_____
3.	_____	_____

In order to revoke my consent for the above individuals to receive my healthcare information; I must submit in writing my revocation of consent directly to Oasis Dermatology HIPAA Compliance Officer: Yvonne Molano.

Phone: (956) 971 - 0404
Email: oasisdermatologynurse@gmail.com

_____ _____

Signature **Date**

OASIS DERMATOLOGY

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Oasis Dermatology Group, PLLC., of McAllen, Texas, hereinafter referred to as "The Practice", or their office staff, may use and disclose PHI (Protected Health Information) about me to carry out TPO (Treatment, Payment and healthcare Operations). Please refer to Oasis Dermatology Group, PLLC., of McAllen, Texas, Notice of Privacy Practices for a more complete description of such uses and disclosures which has been provided to you along with this form. I understand it is my right to review the Notices of Privacy Practices prior to signing this consent. Oasis Dermatology Group, PLLC., of McAllen, Texas, or their office staff, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by visiting the practice and requesting a copy or by forwarding a written request to the Privacy Officer at 3100 Buddy Owens Blvd, McAllen, Texas 78504.

With my consent, The Practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out clinical care, including laboratory results among others.

With my consent, The Practice may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and/or billing.

With my consent, The Practice may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that The Practice, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting The Practice to use and disclose my PHI to carry out TPO. I also have been informed that I have the right to inspect and/or request copies of my child(ren) medical information and to receive an accounting of disclosures that have been made regarding Release of Medical Records/Information.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Practice may decline to provide treatment to me.

You may complain to us through our HIPAA Compliance Officer or to the Secretary of Health & Human Services through the U.S. Department of Health & Human Services Office for Civil Rights if you believe your privacy rights have been violated.

I consent to my medical information being disclosed and used for purposes as stated above.

I also acknowledge that I have been provided with a "**Notice of Privacy Act**" as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and had an opportunity to ask questions and acknowledge that I understand my rights as they pertain to HIPAA and the Texas Privacy Act.

_____ _____

Patient Name (please print) **Date**

_____

Signature of Patient or Legal Guardian

OASIS DERMATOLOGY

Office Financial Policy

Welcome to the Dermatology Clinic of McAllen. In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is the list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, Amex, and Discover.
4. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
5. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to a collection agency and to be reported to one or more credit bureau(s).
6. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have Supplemental Insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have supplemental insurance, your portion (20% of the amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
7. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service-**NO EXCEPTIONS**. If your plan requires you to choose a primary care physician (PCP), it is your responsibility to make sure your insurance company has the physician and/or physician assistant you are seeing as your PCP. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from your PCP. Note that this office does not do retroactive billing or accept retroactive referrals. If we do not participate with your plan, we will verify your out-of-network benefits, and will expect payment of your portion of the charges at the time of service.
8. SELF-PAY PATIENTS: Patients with no Insurance will be expected to pay at the time of service. If you will not be able to pay in full; you must contact our billing department prior to seeing your physician and/or physician assistant to make payment arrangements.
9. Your insurance is a contract between you, your employer, and the Insurance company. ***We are not a party to that contract***. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contract or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

Remember, whether you do not have Insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please feel free to contact us.

I have read and have full understanding of the financial policy of the Dermatology Clinic of McAllen.

_____ _____

Signature **Date**