SAN ANTONIO SKIN AND CANCER CLINIC

PATIENT INFORMATION

DOB____/____/_______

Name (last)____(first)____(MI)________

Address____City__________________________________St______Zip___________

Home Tel # _________________________________Work Tel #_______________________________Cell #______________________________

Social Security # _________________________Sex ____M ____F ____ Marital Status ______________Spouse Name ________________________

Employer Name____Occupation____

Referring Physician ____Tel #____

If patient is a minor: Father's name____ Mother's name ______________________________________

In case of emergency, notify:

______________________________________Primary Tel #____________________Alt. Tel #__________________ Relationship_______________

PRIMARY INSURANCE

Primary Ins Carrier_______________________________ Member ID ______________________________Group # ___________________________

Subscriber name ____________________________________DOB ____/____/______SSN___________________ Relation to patient ____________

Address ______________________________________City _________________________ST_____ Zip ____________Tel #____________________

Name of Employer ____ Emp Tel # _______________________________________

SECONDARY INSURANCE (if applicable)

Secondary Ins Carrier______________________________ Member ID ______________________________Group # _________________________

Subscriber name ____________________________________DOB ____/____/______SSN___________________ Relation to patient ____________

Address ______________________________________City _________________________ST_____ Zip ____________Tel #____________________

Name of Employer ____ Emp Tel # _______________________________________

AUTHORIZATION and ACKNOWLEDGEMENT

I/We hereby state that the above information is true and correct to the best of my/our knowledge. I/We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payers, as required for certain claims filed.
I/We authorize direct payment to be made to the above named practice for any and all-medical or surgical services rendered. I/We understand if my insurance carrier does not cover any services or charges or my eligibility can not be verified, I/We are responsible for all charges incurred.

Signature of Patient/Parent/Guardian/Insured ____Date_________________________

ALLERGIES: (medications, rubber latex, anesthetics: ____

____

Initial Visit Questionnaire

Patient's Name ______________________________ Date __________

Any Medication allergies? If so which ones?

____

Have you or a family member ever been treated for:

	Patient	Family		Patient	Family
High blood pressure	____	____	Stroke/Head Injury	____	____
Heart disease	____	____	Seizures	____	____
Kidney disease	____	____	Vagal fainting episodes	____	____
Lung disease	____	____	Arthritis	____	____
Tuberculosis	____	____	Thyroid problems	____	____
Immundeficiency	____	____	Diabetes	____	____
Stomach problems	____	____	Asthma	____	____
Bowel problems	____	____	Sinus allergies/infections	____	____
Cancer	____	____	**Skin Cancer**	____	____

Have you had your heart valves diseased, floppy or replaced? Yes No

Do you have a cardiac pacemaker? Yes No

Do you take aspirin or other blood thinners? Yes No

Where did you grow up? ______________________________

Did you have sunburns as a child? Yes No

Are you active outside now? Yes No

Have you had X-ray treatment to the skin? Yes No Where?

Have you had:

- Eczema Yes No
- Psoriasis Yes No
- Hives Yes No
- Keloids/abnormal scarring Yes No

Have you had pre-skin cancers frozen? Yes No

Have you had **skin cancers:**

Where/When?

- Basal cell cancer ______________________________
- Squamous cell cancer ______________________________
- Melanoma ______________________________

Current medications (including vitamins, herbs or over the counter)?

____________________ ____________________

____________________ ____________________

____________________ ____________________

Health Habits? (How much?)

- **Caffeines** ______________
- **Tobacco** ______________
- **Alcohol** ______________

SASCC

San Antonio, Texas

San Antonio Skin and Cancer Clinic

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DIPLOMATES OF THE AMERICAN BOARD OF DERMATOLOGY

NAME: ______________________ **DATE:** ______________________

THANK YOU FOR SELECTING THE SAN ANTONIO SKIN & CANCER CLINIC AS YOUR HEALTHCARE PROVIDER. PLEASE READ AND INITIAL THIS OFFICE AND FINANCIAL POLICY PRIOR TO SEEING THE PHYSICIAN.

____ 1. Upon arrival at the office, you/insured/patient will be asked to fully complete multiple forms and present a current insurance card and photo ID. These forms include fields for social security numbers (SSN) for both the patient and the subscriber. If these fields are not completed, the patient/guarantor will be asked to sign a waiver assuming responsibility for total charges billed in the event the claim is denied. Your appointment may be rescheduled if the forms are not fully completed.

____ 2. When there are changes in insurance, demographics, or other pertinent information regarding the patient, a current patient information form indicating these changes will be required to be completed. A current information form will be required to be completed on an annual basis.

____ 3. Referrals required by your insurance must be presented prior to or on the date of service by the patient/insured before seeing the physician.

____ 4. Occasionally you will be asked to sign a waiver when a particular diagnosis is considered to be elective or cosmetic. Any procedure or minor surgery performed may be applied to your annual deductible. Please check your insurance benefits if you have any questions.

____ 5. Co-payments/deductibles will be collected on the date of service if applicable and/or any balance pending on an account for any previous date of service.

____ 6. All charges incurred on the date of service will be the responsibility of the insured/responsible party/patient if not covered by your insurance carrier.

____ 7. If a biopsy is performed in the office by one of our providers, a specimen will be submitted to an outside dermatopathology laboratory. A separate bill for the processing and the diagnosis of your biopsy specimen will be submitted to your insurance carrier and/or to the patient if paying privately.

Again, thank you for choosing the San Antonio Skin and Cancer Clinic for your medical needs.