The Skin Surgery Center of Houston

PATIENT REGISTRATION

Welcome and thank you for visiting our office today! We are committed to providing you with quality care. Please make yourself comfortable and let us know if we can assist you with anything.

Date _____ *E-mail Address* _____

Name: _____
First *Middle Initial* *Last*

Address: _____
Street *City* *State* *Zip* *Country*

Phone: _____
Home *Cell* *Work/Alternate*

Date of Birth: _____ *SSN:* _____ *Married* ____ *Single* ____ *Widowed*_____ *Other* _____

Patient's Employer _____ *Occupation* _____

Emergency Contact _____ *Phone* _____ *Relationship* _____

*Are you the **primary** insurance policyholder? Yes* _____ *No* _____ *If No, please tell us who is below.*

Primary Policyholder _____
First *Middle* *Last*

Relation to Patient _____ *Date of Birth* _____ *SSN* _____

AUTHORIZATION OF TREATMENT & ASSIGNMENT OF INSURANCE BENEFITS

I authorize Skin Surgery Center of Houston to perform medical and/or surgical procedures as deemed necessary. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim. I also agree, and understand that if my insurance company does not reimburse, Skin Surgery Center of Houston within 60 days, I give my full and written consent to file a normal written complaint with the Insurance Commissioner. I acknowledge and understand that I am responsible for all of the charges for the services rendered to me or any member of my family. The information above is complete and accurate to the best of my knowledge.

Signature of Patient or Guardian _____ ***Date*** _____

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PATIENT MEDICAL HISTORY

This information is considered confidential as part of a patient/physician relationship. THE INFORMATION, PROVIDED BELOW WILL NOT BE RELEASED WITHOUT YOUR WRITTEN AUTHORIZATION. Please answer completely and accurately to the best of your knowledge.

Name: _____
First Middle Initial Last

Reason for Consultation? _____

Height _____ Weight _____ Age _____

Pharmacy _____ Address or Cross Streets _____ Phone _____

Please list all medical problems/conditions past or present: _____

Please list any previous surgeries or accidents: _____

Family History:

Family Members	Deceased, Alive or Unknown	Age of diagnosis	Diabetes I or Diabetes II	Hypertension (high blood pressure)	Heart Disease	Stroke	Cancer (type)
Father							
Mother							
Siblings							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							

Do you have or have you had any of the following? Please circle yes or no.

Asthma	Yes	No	Seizures	Yes	No	Heartburn	Yes	No
Bronchitis	Yes	No	Stroke	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Kidney Disease	Yes	No	Stomach Problems	Yes	No
Breathing Difficulty	Yes	No	Dizziness	Yes	No	Intestinal Problems	Yes	No
Pneumonia	Yes	No	Tuberculosis	Yes	No	Hay Fever	Yes	No
High Blood Pressure	Yes	No	Liver Disease	Yes	No	Depression	Yes	No
Heart Disease	Yes	No	Cirrhosis	Yes	No	Cancer	Yes	No
Heart Attack	Yes	No	HIV/AIDS	Yes	No	Sinus Problems	Yes	No
Chest Pain	Yes	No	Hepatitis	Yes	No	Headaches	Yes	No
Diabetes	Yes	No	Thyroid Problems	Yes	No	Migraines	Yes	No
Pacemaker/Defibrillator	Yes	No	Fever Blisters	Yes	No	Arthritis	Yes	No

Have you had a flu shot? ☐ Yes ☐ No If YES, when? _____ / _____ / _____ Comments: _____
mm dd yyyy

Please list all medications you are currently taking: _____

Do you take Aspirin, Coumadin, Plavix, or any other blood thinners? _____

Any known allergies? (please list) _____

Are you a smoker? _____ If so, how much? _____ Do you drink alcohol? _____ If so, how much? _____

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PATIENT QUESTIONNAIRE AND HIPAA ACKNOWLEDGEMENT

Patient Name (print): _____ Date: _____

You may be contacted by the practice to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.

Do we have permission to:

Leave a message on your answering machine at home? ____ Yes ____ No

Leave a message on your cell phone? ____ Yes ____ No

Leave a message at your place of employment? ____ Yes ____ No

Discuss your medical condition with a family member? ____ Yes ____ No

If yes, who? _____ Relationship _____ Telephone _____

Comment:

_____

Skin Surgery Center of Houston has provided me with a copy of my rights (find a copy on our web site or ask for a copy in the office) as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction. If you have questions, please address them with your physician during your visit.

_____ _____

Patient's/Guardian Signature Date