Texas Dermatology Center, Dr. Mary Evers

Initial Patient Questionnaire

Patient's Name_____ Age_____

Today's Date_____ Referring Doctor_____

Medications currently taking * **Names Only*** _____

_____

Allergies: _____

Past Medical History:

YES NO		YES NO	
☐ ☐	Skin Cancer	☐ ☐	HIV / Aids
☐ ☐	Skin Disease or Keloid Scars	☐ ☐	Organ / Bone Marrow Transplant
☐ ☐	High Blood Pressure	☐ ☐	Autoimmune Disease / Lupus
☐ ☐	High Cholesterol	☐ ☐	Arthritis
☐ ☐	High Disease / CHF	☐ ☐	Bleeding Disorders
☐ ☐	Liver Disease / Hepatitis	☐ ☐	Cancer
☐ ☐	Kidney or Bladder Disease	☐ ☐	Asthma / Hay Fever / Sinus Trouble

Family History

☐ Skin Disease

☐ Skin Cancer

☐ Autoimmune Disease

Social History

YES NO		YES NO	
☐	☐ Do you smoke	☐	☐ Do you regularly use sunscreen
☐	☐ Do you drink alchol	☐	☐ Have you had a sunburn
☐	☐ Do you use illicit drugs	☐	☐ Occupation_____

Female Patients Only

Yes NO

☐ ☐ Currently Pregnant

☐ ☐ Breastfeeding

☐ ☐ Planning Pregnancy

Patient or Responsible Party Signature_____Date_____

Physician Signature_____ Date_____

TEXAS DERMATOLOGY CENTER PLLC, DR. MARY EVERS, D.O.

Name: _____ Todays Date_____

Date of Birth:___ / ___ / ___ Age: _____ Sex: ☐ Male ☐ Female

Mailing Address: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ E-mail Address: _____

Referred by: _____

Have you or any family members been a patient of Dr. Evers? _____

Primary Care Physician _____ Phone: ( ) _____

PARENT, SPOUSE, OR RESPONSIBLE INSURED PARTY (if different from patient):

Name: _____ Date of Birth: _____ / _____ / _____

Address: _____

Cell Phone: ( ) _____ Work Phone: ( ) _____

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified: _____

Phone number: ( ) _____ Relationship to Patient: _____

Do you give our office permission to discuss your medical information with family members? ☐ **YES** ☐ **NO**
If yes, please provide their names and phone numbers below:

Name: _____ Relationship: _____

Phone # Day: _____ Phone # Evening: _____

Name: _____ Relationship: _____

Phone # Day: _____ Phone # Evening: _____

May we leave personal medical information on your answering machine or cell phone?

☐ Yes ☐ No

Pharmacy: (name and location) _____

Patient or Responsible Party Signature _____ **Date:** _____

ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that Texas Dermatology Center, PLLC provided me with a written copy of his / her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature: _____

Date: _____

Personal Representative Signature / Parent if patient is a minor:

_____ Date: _____

TEXAS DERMATOLOGY CENTER PLLC, DR. MARY EVERS, D.O.

3201 South Austin Avenue, Suite 115, Georgetown, TX 78626

Phone 512-868-9800 Fax 512-868-9811

OFFICE FINANCIAL POLICY

Patient name: _____ Date of Birth: ____ / ____ / ___

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you as the patient, to please check with your insurance company prior to any testing or surgery being performed. ***It is your responsibility to know your individual coverage.*** Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

LAB / PATHOLOGY: I authorize and understand that an outside laboratory is used to process and interpret the skin specimens. I understand that this is a separate charge from today's services. If your insurance company requires you to use a specific Laboratory please notify our staff today prior to the procedure. **Please remember, your insurance policy is between you and your insurance company *and not with the insurance company and your doctor.***

Medicare: We are Medicare participating providers. We will bill Medicare and Medigap carriers. **You will be responsible at the time of service for payment of:**

The annual deductibles, Copayments and Charges for noncovered or cosmetic services. *You will be asked to sign an Advanced Notice of Liability Form in the even that a service is provided which we know is not covered by Medicare. If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary / supplemental carrier. If no payment is received from your secondary / supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Non-Medicare / Commercial Plans: If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill both your primary and secondary insurance plans for contracted plans. **You will be responsible at the time of service for payment of:**

The annual deductibles, Copayments and Charges for non covered or cosmetic services. In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier with which we do not have a contractual relationship, please note the following:

We will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement. b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

No Insurance: Payment is expected at the time of service. A discount will be given for those with no medical insurance and payment at the time of service.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ ____ / ____ / ____

Patient or Responsible Party Signature Date