# Welcome to Lakeway Dermatology

For your convenience you may complete a portion of the patient forms prior to your visit and submit the forms electronically. Alternatively, you may print, complete and bring the entire forms packet to your appointment (PDF).

Please remember to bring

* Completed Forms if not submitted online
* Insurance Card (s)
* Co-payment. We accept cash, check, debit, Visa®, MasterCard®, American Express®, Discover® and Care Credit®
* Parent or guardian must accompany all patients under 18 years of age to first visit
* Caretaker must accompany incapacitated patients

We are located in our new facility at
3464 RR 620 South
Bee Cave, TX 78738
At the Entrance to Falconhead
T512-263-0057 F512-263-0221
www.lakewaydermatology.com

LAKEWAY DERMATOLOGY
Skin Cancer, Cosmetic & Laser Center

# Patient Registration Form

## PERSONAL INFORMATION

Name: First ____________________________ MI ___ Last ______________________________ Nickname _________

Social Security # _____ - ____ - _____ Date of Birth _____ / ____ / _____ Driver's License ___________

Marital Status: ❏ Single ❏ Married ❏ Divorced ❏ Widowed ❏ Partnered   Sex: ❏ M ❏ F

Race: ❏ White ❏ African American ❏ Asian ❏ Other ❏ Decline

Ethnicity: ❏ Non-Hispanic ❏ Hispanic ❏ Other ❏ Decline

Preferred Language (if other than English): ______________________

Address: Street __________________________________ Apt _____ City ___________ State ____ Zip ________

Phone Numbers: Home (___) _____________ Cell (___) ____________ Work (___) ___________

E-mail Address: ___________________________

## PERSON RESPONSIBLE FOR BILL (if different than patient)

Name: ___________________________________ Relationship to Patient: ❏ Self ❏ Spouse ❏ Parent ❏ Other

Date of Birth ____ / ____ / _____   Phone: (___) ___________

Address: Street _________________________ Apt _____ City ___________ State ____ Zip ________

## PRIMARY MEDICAL INSURANCE (In order to file a claim on your behalf, please fill out completely)

Insurance Company: _____________________________

Insurance Company Address: Street _________________________ City _______________ State ____ Zip _____

Subscriber's Name: ___________________________ Subscriber's Date of Birth ____ / ____ / _____

Relationship to Patient: ❏ Self ❏ Spouse ❏ Parent ❏ Other

Subscriber ID: ________________________ Group ID: _________________________

## SECONDARY MEDICAL INSURANCE (if applicable)

Insurance Company: _____________________________

Insurance Company Address: Street _________________________ City _______________ State ____ Zip _____

Subscriber's Name: ___________________________ Subscriber's Date of Birth ____ / ____ / _____

Relationship to Patient: ❏ Self ❏ Spouse ❏ Parent ❏ Other

Subscriber ID: ________________________ Group ID: _________________________

## PREFERRED PHARMACY

Name: ____________________ Address __________________________ Phone: (___) ___________

## EMERGENCY CONTACT

Name: ___________________________________ Phone: (___) ___________

Relationship to Patient: ❏ Spouse ❏ Parent ❏ Child ❏ Other

LAKEWAY DERMATOLOGY
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# Personal Health History

Patient Name: ______________________________ Date of Birth ____ / ____ / ____

Today's Date ____ / ____ / ____ Reason for Visit: ______________________________

MEDICAL CONDITIONS (Please check the conditions that apply) ❑ None

❑ Allergies ❑ Seasonal ❑ Skin ❑ Latex ❑ Lidocaine
❑ Asthma
❑ Bleeding Tendency
❑ Cancer: of what origin?
❑ Depression or Anxiety
❑ Diabetes
❑ Eczema
❑ Heart Disease or Atrial Fibrillation
❑ Heart Valve Replacement
❑ Hepatitis ❑ A ❑ B ❑ C
❑ Herpes ❑ Cold Sore ❑ Genital
❑ High Blood Pressure
❑ HIV/Aids
❑ Joint Replacement. Do you need premedication prior to procedures ❑ yes ❑ no
❑ Keloids or Excessive Scarring or Problems with Healing
❑ Kidney Disease
❑ Liver Disease
❑ Lung Disease
❑ Lupus
❑ Pacemaker or Defibrillator
❑ Psoriasis
❑ Seizures
❑ Skin Cancer
  ❑ Basal Cell
  ❑ Squamous Cell
  ❑ Melanoma
  ❑ Other
❑ Thyroid Disease
❑ Stroke

ALLERGIES TO MEDICATIONS ❑ None

Name of the drug ______________________ Reaction you had ______________________

______________________ ______________________

Current Medications including over-the-counter drugs, vitamins and supplements ❑ None

______________________ ______________________

______________________ ______________________

______________________ ______________________

LAKEWAY DERMATOLOGY

Skin Cancer, Cosmetic & Laser Center

# Personal Health History

Patient Name: ________________________________ Date of Birth ____ / ____ / ____

Any additional medical problems other doctors have diagnosed?

________________________________________________________________

SURGERIES None

| Year | Reason | Year | Reason |
|---|---|---|---|
| ______ | ______________________ | ______ | ______________________ |
| ______ | ______________________ | ______ | ______________________ |

HEALTH HABITS

What is your occupation? ______________________________

Do you use a tanning bed? ❏ Yes ❏ No ❏ Former User

Do you smoke? ❏ Yes ❏ No ❏ Former User

Do you drink alcohol? ❏ Yes ❏ No ❏ Former User

Do you use recreational drugs? ❏ Yes ❏ No ❏ Former User

Have you had your Flu immunization? ❏ Yes ❏ No

Have you had your Pneumonia Vaccination? ❏ Yes ❏ No

FAMILY HISTORY

Has anyone in your family ever had:

Melanoma ❏ Yes ❏ No

Other Skin Cancer ❏ Yes ❏ No

Psoriasis ❏ Yes ❏ No

Hypertension ❏ Yes ❏ No

FEMALE PATIENTS ONLY

Are you pregnant? ❏ Yes ❏ No

Using contraception? ❏ Yes ❏ No

If Yes, what type? __________

Trying to get pregnant? ❏ Yes ❏ No

Breastfeeding? ❏ Yes ❏ No

COSMETIC CONCERNS (optional)

Do you have cosmetic concerns you would like to discuss? ❏ Yes ❏ No

MESSAGES REGARDING LAB/PATHOLOGY RESULTS

When we are unable to reach you directly regarding benign/normal lab or pathology results, we typically leave a voicemail or answering machine message with the result(s). The decision about whether to leave a detailed message is at the discretion of the staff of Lakeway Dermatology.

❏ I do not want to receive any results on my voicemail or home answering machine, only call back details.

# Acknowledgement of Office Policies

Patient Name: ______________________________________ Date of Birth ____ / ____ / _____

Parent/Guardian Name (if applicable: ______________________________________

Insurance Filing Authorization

I certify that the information contained in my registration and health history forms is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Lakeway Dermatology. I also authorize Lakeway Dermatology or insurance company to release any information to process my claims. I agree a photocopy or scan of this agreement shall be valid as the original.

Notice of Privacy Practices

I have read a copy of Lakeway Dermatology's Notice of Privacy Practices which explains how my medical information will be used and disclosed. This document is available at the front desk upon check in and on our website. I authorize the release of any medical information necessary to evaluate or treat my condition. I further authorize the release of any medical information necessary to process insurance claims on my behalf or on the behalf of my dependents.

Financial Policy

Payment is due at the time of service. This amount includes any co-pays as well as the amount of outstanding insurance deductibles or co-insurance. I understand that I am financially responsible for all charges for services rendered on my behalf or on the behalf of my dependent, whether or not they are covered by my insurance. I understand it is my responsibility to obtain necessary referrals and to know who my insurance company requires me to utilize for ancillary services.

Consent to Treatment

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical providers and staff as is deemed necessary in the medical provider's judgement.

Signature: ________________________________ Date ____ / ____ / _____

# Authorization to Disclose Medical Information

Patient Name: ______________________________ Date of Birth ____ / ____ / ____

Parent/Guardian Name (if applicable: ______________________________

In the event the physicians and staff of Lakeway Dermatology need to contact you regarding an appointment, medication, or pathology/lab result, I hereby authorize the disclosure and details of my medical diagnosis, treatment, and billing/claims information to the following individuals.

You do not need to list your other physicians or insurance company

| Name | Relationship | Phone |
|---|---|---|
| ____________________ | ____________________ | (____) ______________ |
| ____________________ | ____________________ | (____) ______________ |
| ____________________ | ____________________ | (____) ______________ |

❏ I elect not to authorize disclosure to any individuals at this time.

This authorization is voluntary and I understand that I have the right to revoke this authorization by submitting a written request to the Practice Administrator for Lakeway Dermatology. I understand the information disclosed under this authorization may be disclosed again by the person to which it is released. I understand that the above list may not be exhaustive and that my protected health information may be disclosed to additional individuals based on my verbal authorization or as indicated in our Notice of Privacy Policies. This authorization shall remain in effect indefinitely unless revoked by me in writing.

Signature: ______________________________ Date ____ / ____ / ____