WHITE ROCK DERMATOLOGY

10611 Garland Road, Suite 210; Dallas, TX 75218 Tel: 214-324-2881

Date: _____

Patient's Full Name: _____ Gender: _____ Age: _____

Marital Status: Single_____ Married_____ Widowed_____ Divorced_____

DOB: _____ Social Security Number: _____ Occupation: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Employer: _____

Spouse/Parent Name: _____ Work Phone: _____

Please provide the following information for the person who will be responsible for the payment of medical bills (if different from above):

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Emergency Contacts:

Nearest relative not living with you: _____ Phone: _____

Relationship: _____

Nearest friend not living with you: _____ Phone: _____

Referred by: _____ ( ) Doctor ( ) Family ( ) Friend ( ) Ins. Plan ( ) Phone Book

Name of Family Physician: _____

Covered by health insurance? ( ) Yes ( ) No If yes, the name of your plan: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE:

Name of Parent/Guardian: _____ Work #: _____ Employer: _____

If I find that I am unable to accompany my above child/young adult to an appointment, I hereby grant to White Rock Dermatology permission to examine and treat my child is and when he/she arrives at the office unaccompanied.

_____ _____

Signature of Parent/Guardian Date

NAME_____ DATE _____

Current Skin Problems: State in your own words the problem for which you are seeing the doctor:

	Skin Problem and Location	**Duration**	**Previous Treatment**
1.			
2.			
3.			

IMPORTANT: Are you allergic to any medications? _____Yes _____No If yes, please list them:

_____.

Please list any medications that you are currently taking or take more than occasionally (or provide a list):

_____.

_____.

MEDICAL HISTORY: (Please check if you have had the following):

( ) Hay Fever/Asthma	( ) Kidney Disease	( ) Eczema	( ) Yeast Infections
( ) Peptic Ulcer	( ) Tuberculosis (TB)	( ) High Blood Pressure	( ) Cancer
( ) Diabetes	( ) Heart Disease	( ) Bleeding Tendency	( ) Epilepsy
( ) Hepatitis/Liver Disease	( ) Hives	( ) Thick Scars (keloids)	( ) Thyroid Disease

( ) Other illnesses (please specify)_____

Do you smoke? _____ Drink Alcohol? _____ Special Diet? _____ Exercise Routinely? _____

Do you have a heart pacemaker? _____Yes ____No

Women: Are you pregnant? ____Yes ____No If yes, Due Date_____

HISTORY OF SKIN PROBLEMS:

Previous Skin Diseases: _____

Have you been under the care of a dermatologist within the past five years? ____Yes ___No

Personal History of Skin Cancer: ___Yes ____No Type: _____

Risk Factors for Skin Cancer: ( ) Radiation Exposure ( ) History of multiple sunburns ( ) PUVA treatments

( ) Chronic Immunosuppression (organ transplantation, chemotherapy, AIDS)

Family History of Skin Cancer: ____ Yes ____ No If yes, who and type: _____

Family History of Skin Disease (please specify): _____

Please provide any information which you believe is important for the doctor to know and is not included above:

My signature below signifies that the above information is correct to the best of my knowledge and provides my consent for examinations necessary to diagnose and treat my skin conditions.

Guardian/

Patient Signature:_____Date_____ Doctor's initials:_____Date:_____

This form was completed by: ( ) Patient ( ) Spouse/Parent ( ) Other _____

WHITE ROCK DERMATOLOGY

Elizabeth Dolan, M.D.

10611 Garland Rd., Suite 210

Dallas, Texas 75218

Telephone: 214-324-2881 **Fax: 214-328-4084**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Not infrequently we are asked to provide information related to your care to your primary care physician and/or to your insurance carrier to resolve issues related to charges. Spouses and/or children frequently request the results of laboratory studies and biopsy reports. Without your authorization we cannot provide such basic information to anyone except you the patient. This simple form is to allow you to provide that authorization, or to specifically deny such authorization when appropriate.

I hereby authorize the release of information from my medical record to the following:

_____ Primary Care Physician
_____ Other Specialty Care Physician from whom I receive care
_____ Spouse
_____ Parents
_____ Children and their spouses
_____ Other (specify) _____

(Please check any of the above that you specifically wish to include.)

I understand that information released is for the purpose of providing quality continued patient care. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

May we leave medical information on your home answering machine if we are unable to reach you? YES NO (Please circle appropriate response)

Patient name_____ Date of Birth_____

_____ _____
Signature of Patient or Legal Representative Date
Parent or Legal Guardian must sign for patient
Under 18 years of age.

_____ _____
Relationship to Patient if other than self Witness

PLEASE SIGN
SO WE HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes that I am responsible for all charges. I authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical benefits to which I am entitled to White Rock Dermatology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Signature:_____Date:_____

WHITE ROCK DERMATOLOGY

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

Our Notice of Privacy Practices provides information as to how we may use and disclose protected health information about you. You have been given a copy of our Notice of Privacy practices. The terms of our Notice may change. You may obtain a revised copy by contacting our office.

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By signing this form, I acknowledge that I have received a copy of the Notice Of Privacy Practices and consent to the disclosure of protected health information about me for treatment, payment and health care operations as described in the Notice of Privacy Practices. White Rock Dermatology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature of Patient or Patient Representative **Date**

_____

Relationship to Patient
(if signed by other than patient)

Patient Name:
DOB:

Tobacco User, includes chewing tobacco: (Please choose one)

____ Never Smoker/User

____ Former Smoker/User

____ Current Smoker/User

Alcohol Intake

_____ Yes

_____ No

Have you received the following:

Flu Shot: _____ When: _____ (this question is Oct 1 – March 30)

Pneumonia Shot: _____ (for pts 65 and up)

New Shingles Vaccine: _____
If yes, did you receive second shot? _____

Do you an Advanced Care Directive: (for pts 65 and up)
If so, who? _____

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ELIZABETH T. DOLAN, M.D.
CHRISTY C. RIDDLE, M.D.
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Dallas, TX 75218
Tele: 214-324-2881 Fax: 214-328-4084

24 HR CANCELLATION & "NO SHOW" FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, White Rock Dermatology reserves the right to charge a fee of $25.00 for medical and $50.00 for surgical or cosmetic appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

If you are running late for your appointment, please have the courtesy to call and let us know. We will make every attempt to work you back into the schedule for that day or reschedule for another appointment time.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____
PRINTED NAME DATE

_____ _____
SIGNATURE DOB

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If your insurance plan requires a referral authorization from a primary care physician, you are responsible for presenting this referral at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.
If you have contacted your primary care physician and you feel that they will get a referral number to us, we will see you and file your claim for you. If your primary care physician neglects to get the referral to us and your claim is denied, you will be responsible for full payment of the visit.

By your signature below, you are stating that you understand the above policy.

Patient Name (print): _____

Patient Signature: _____

Date: _____