Welcome to our practice!

We appreciate the opportunity to care for your skin!

The office is open Monday-Friday 8:00am-5:00pm.

We see all patients on an appointment basis and ask that you call in advance so that we may reserve time for you. If you cannot keep an appointment, please notify us immediately, when possible. We ask that you give us at least a 24 hours notice so that the time may be given to another patient.

Please bring updated medication lists and insurance information with you to each visit so that we may keep your medical record up to date and provide you with optimal care.

At Advanced Dermatology, we want to be a blessing for those we serve. To care for not only the skin, but to fully care for all who walk through our door. To prevent illness when we are able, to cure whenever possible, and to provide care and support when no cure can be found. We pledge to be more than just a clinic. We pledge to be a companion in your care and to treat each patient as if they were a part of our own family. Again, welcome to our clinic; we look forward to seeing you.

Advanced Dermatology & Skin Cancer Institute
4709 66th Street Lubbock, TX, 79414
P: 806 701 5844 F: 806 701 5845

Patient Information

Last **First** **Middle** **Nickname** **Date of Birth** **Male/Female**

Marital Status **Patient's Social Security Number** **Place of birth:** City, State, Zip

Preferred Language **Race** **Ethnicity** **Preferred Contact Method**

Please Circle your preferred contact Number. Can we leave a detailed message? YES NO

Home Phone Number **Cell Phone Number** **Work Phone Number**

Emergency Contact Name **Relationship** **Emergency Contact Number**

Spouse Full Name **Contact Number** **Caretaker Full Name** **Contact Number**

Patient's Email ***(We will send you a patient portal link)***

Patient's Street Address **City** **State** **Zip Code**

Guardian/Parent's Name ***(IF APPLICABLE)*** **Date of Birth** **Patient Employer Info: Name, Occupation, Industry**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Skin Cancer Institute or Insurance Company to release any information required to process my claim(s).

Patient's/Guardian's Signature **Date**

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Insurance Information

Primary **Insurance Company** **Member ID Number** **Group Number**

Secondary **Insurance Company** **Member ID Number** **Group Number**

Subscriber's Name **Relationship to Subscriber** **Subscriber's Phone Number**

Subscriber's Date of Birth **Subscriber's Social Security Number**

Subscriber's Street Address **City** **State** **Zip Code**

Pharmacy Information

Preferred Pharmacy **Pharmacy Phone Number**

Pharmacy Address **City** **State** **Zip Code**

Primary Care Physician Information

Primary Care Physician **PCP Phone Number**

Referring Physician ***(IF APPLICABLE)***

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Past Medical History *(Please circle all that apply)* *NONE*

Anxiety	COPD	Hypertension	Prostate Cancer
Arthritis	Coronary Artery Disease	HIV/AIDS	Radiation Treatment
Asthma	Depression	Hypercholesterolemia	Seizures
Atrial Fibrillation *(Irregular Heartbeat)*	Diabetes	Hyperthyroidism (High)	Stroke
Bone Marrow Transplant	End Stage Renal Disease	Hypothyroidism (Low)	
BPH *(Enlarged Prostate)*	GERD/ Reflux	Leukemia	
Breast Cancer	Hearing Loss	Lung Cancer	
Colon Cancer	Hepatitis	Lymphoma	

*Other:*_____

Past Surgeries *(Please circle all that apply)* *NONE*

Appendix (Appendectomy)	Bladder (Cystectomy)
Breast Biopsy	Breast: Lumpectomy: Left Right Both
Breast: Mastectomy: Left Right Both	Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis	Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy	Gallbladder (Cholecystectomy)
Heart: Biological Valve Replacement	Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant	Heart: Mechanical Valve Replacement
Heart: PTCA	Joint Replacement: Hip: Left Right Both
Joint Replacement: Knee: Left Right Both	Kidney Biopsy Kidney Transplant Kidney: Nephrectomy
Liver: Hepatectomy	Liver Transplant Liver: Shunt
Ovaries (Oophorectomy): Endometriosis	Ovaries (Oophorectomy): Ovarian Cancer
Ovaries (Oophorectomy): Ovarian Cyst	Pancreas: Pancreatectomy
Prostate (Prostatectomy): TURP	Prostate (Prostatectomy): Prostate Biopsy
Prostate (Prostatectomy): Prostate Cancer	Rectum: APR Rectum: Lower Anterior Resection
Skin Biopsy Skin: Melanoma	Skin: Squamous Cell Carcinoma Spleen (Splenectomy)
Testicles (Orchiectomy)	Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer	Uterus (Hysterectomy): Cervical Cancer

Other Surgeries *not* listed: _____

_____

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Skin Disease History *(Please circle all that apply)* *NONE*

Acne	Dry Skin	Poison Ivy
Asthma	Eczema	Precancerous Moles
Actinic Keratosis	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Other: _____

Do you wear sunscreen? YES NO **Do you tan in a tanning salon?** YES NO

If yes, what SPF? _____

Family History

Do you have a family history of Melanoma? YES NO

If yes, which family member/relative? _____

Medication List *List of medications and dosage* NONE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

Do you have any food or drug allergies? YES NO *If yes, please list below*

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

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Social Status

Do you smoke? YES NO

Never a Smoker Unknown Former smoker

Heavy tobacco smoker Current every day smoker Light tobacco smoker

Current someday smoker Current someday tobacco Cigar smoker

Date you started smoking: _____ Date you quit smoking: _____

Number of packs a day? _____ Total number of years smoking? _____

Illicit Drugs use: YES NO **IV Drug use:** YES NO (*Used in the last 12 mo.:* YES NO)

Sexually Active: NONE 1 partner >1 Partner Same sex partner

Alcohol use: NONE Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day

How many times in the past year have you had 4 or more drinks a day (5 or more for men<65years) _____

***Patient feel safe in home**:* YES NO

Do you drive in the day time**?* YES NO ***Do you drive in the night time? YES NO

How often do you exercise?

Once a day Several times a day Few times a week Few times a month Never

How often do you have caffeine?

Once a day Several times a day Few times a week Few times a month Never

Occupation and Workplace:

_____

City and State of residence:

_____

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Privacy Policy

With your consent, Skin Cancer Institute may call, mail or email you regarding anything pertaining to your healthcare treatment, including payment and other operations such as appointment reminders. By signing this form, you consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your Health Insurance Company, and overall health care instances.

Telephone Communication: Please indicate if you would like for us to leave information regarding your care on your voicemail. Please initial by the option of your choice and include a phone number, and if you would like for us to leave a detailed message regarding your healthcare, including lab or pathology results.

_____ Leave a detailed message about my healthcare. Phone Number: _____

_____ Leave a message with a call-back number only.

Persons Authorization to Receive Information About Your Care:

I Authorize Skin Cancer Institute to release medical, appointment, and/or financial information over the telephone or in person to the following person(s):

1. _____
   Name Relationship Telephone Number

2. _____
   Name Relationship Telephone Number

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name of Patient or Legal Representative: _____

Consent for Examination, Treatment and Financial Responsibility Agreement

I hereby consent to and authorize the physician(s) and employees at Skin Cancer Institute to provide care to me during my office visits. I authorize the release of appropriate medical information for the purpose of processing insurance claims on my behalf. I understand that I am financially responsible for services provided which are to be paid on the date of service. I also understand that the filing of an insurance claim is not a guarantee of payment, and that I am financially responsible for payment if a claim is unpaid or denied by the insurance company.

I authorize the release of my medical information to my primary care physician, referring physician, and/or consultants as necessary to carry out proper medical treatment. I understand that photography may be necessary for planning and evaluating treatment, and authorize taking photographs at the direction of the physician. This is solely for documentation purposes. They will be kept confidential unless otherwise disclosed.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name of Patient or Legal Representative: _____