Dermatology and Laser Medicine of Southeast Texas

350 Pine St. STE 1438
Beaumont, TX 77701
Office: (409) 835-2737
Fax: (409) 835-7546

Today's Date: _____/______/_________

Patient's Name: ____

Parent/ Guardian *(if minor)*: ____

Mailing Address: ____

City/ State/ Zip: ____

Primary Phone: _____________________ Work/ Cell: ____________________ Email: ________________________

Preferred Contact *(please circle)*: Call Text Email

D.O.B: ____/_____/_________ Sex: _______ DL#: _______________________ SS #: ________-________-__________

Marital Status: ___________________________ Religion: _____________________ Race: ____________________

Ethnicity *(please circle)*: Hispanic or Latino Non-Hispanic or Latino Other Unknown Declined

Employer: __________________________________ Occupation: ____

Primary Care Physician: ____

Emergency Contact Information *(Please provide a contact NOT living with you)*

Name: ___________________________________ Relationship: ____________________ Phone: ________________

Responsible Party

Insurance Subscriber: ____

Address/ City/ State/ Zip: ____

Relationship to Patient: ____________________________ SS#: _______-______-_______ D.O.B: ____/_____/_______

Employer: ____ Occupation: _____________________________________

Primary Phone: _______________________ Work/ Cell: ________________________ Other: ____________________

Primary Insurance

Ins. Co.: _________________________________

Policy #: _________________________________

Subscriber/ D.O.B.: _________________________

Secondary Insurance

Ins. Co.: ______________________________

Policy #: ______________________________

Subscriber/ D.O.B: _______________________

Does your insurance require a referral from your family care doctor? YES NO

Authorization and Release *(Please sign below)*

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits be made to Dermatology and Laser Medicine of Southeast Texas. I acknowledge that I am financially responsible for payment of services not covered by insurance.

Signature: ____ **Date:** ______/______/________

History and Intake Form

Past Medical History *(Please circle all that apply)*:

Anxiety	Depression	Lung Cancer
Arthritis	Diabetes	Lupus
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation (Irregular Heartbeat)	GERD	Multiple Sclerosis
Blood Clots	Hearing Loss	Pacemaker/ Defib.
Bone Marrow Transplantation	Hepatitis	Prostate Cancer
BPH	Hypertension	Radiation Treatment
Breast Cancer	HIV/ AIDS	Rheumatoid Arthritis
Colon Cancer	Hypercholesterolemia	Scleroderma
COPD	Hypothyroidism	Seizures
Coronary Artery Disease	Inflammatory Bowel Disease	Stroke
Crohn's Disease	Leukemia	Ulcerative Colitis
		NONE

Other: ____

Appendix (Appendectomy)	Heart: PTCA	Pancreas: Pancreatectomy
Bladder (Cystectomy)	Joint Replacement: Hip (Both, Left or Right)	Prostate: Prostate Biopsy
Breast: Breast Biopsy	Joint Replacement: Knee (Both, Left or Right)	Prostate: Prostatectomy
Breast: Lumpectomy (Both, Left or Right Breasts)	Kidney: Kidney Biopsy	Prostate: TURP
Breast: Mastectomy (Both, Left or Right Breast)	Kidney: Kidney Stone Removal	Rectum: APR
Colon (Colectomy): Colon Cancer Resection	Kidney: Kidney Transplant	Rectum: Low Anterior Resection
Colon (Colectomy): Diverticulitis	Kidney: Nephrectomy	Skin: Basal Cell Carcinoma
Colon (Colectomy): Inflammatory Bowel Disease	Liver: Hepatectomy	Skin: Melanoma
Colon: Colostomy	Liver: Liver Transplant	Skin: Skin Biopsy
Gallbladder (Cholecystectomy)	Liver: Shunt	Skin: Squamous Cell Carcinoma
Heart: Biological Valve Replacement	Ovaries (Oophorectomy): Endometriosis	Spleen (Splenectomy)
Heart: Coronary Artery Bypass Surgery	Ovaries (Oophorectomy): Ovarian Cancer	Hysterectomy: Fibroids
Heart: Heart Transplant	Ovaries (Oophorectomy): Ovarian Cyst	Hysterectomy: Uterine Cancer
Heart: Mechanical Valve Replacement	Ovaries: Tubal Ligation	Hysterectomy: Cervical Cancer
		NONE

Other: ____

Past Surgical History *(Please circle all that apply)*:

Family History *(Please circle all that apply)*:

Crohn's Disease	Multiple Sclerosis	Rheumatoid Arthritis
Dermatomyositis	Psoriasis	Ulcerative Colitis
Inflammatory Bowel Disease	Psoriatic Arthritis	None
Lupus	Scleroderma	

Skin Disease History *(Please circle all that apply)*:

Acne	Flaking or Itchy Scalp
Actinic Keratoses	Hay Fever/Allergies
Asthma	Melanoma
Basal Cell Skin Cancer	Poison Ivy
Blistering Sunburns	Precancerous Moles
Dry Skin	Psoriasis
Eczema	Squamous cell skin cancer
	NONE

Other: ____

Social History *(Please circle all that apply)*

Tobacco Use:

- Unspecified
- Current every day user (Tobacco)
- Current every day smoker (Cigarettes)
- Former Smoker
- Never Smoker

Alcohol Use:

- None
- 1 Drink per day
- 1-2 Drinks per day
- 3 or more drinks per day

Do you wear Sunscreen? Yes No
If yes, what SPF? ___________
Do you tan in a tanning salon? Yes No

Family History of Melanoma? Yes No

If yes, which relative(s)? ____

***** Please keep in mind your appointment is scheduled for the evaluation of a single dermatological problem. If you have several dermatological problems, please plan to return at separate times for evaluation of each, individually. For example, if you have acne and you also have warts, plan to come in for each of these at different times.***

Reason for Today's Visit: ____

Pharmacy: ______________________________________

Medications *(Please list all current medication)*
____
____
____
____
____

Allergies *(Please list all allergies)*
____
____
____
____
____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient : _______________________________________ D.O.B: _____/______/________ SS# : _____-______-_______

I understand, on occasion, I may request for Dermatology and Laser Medicine of Southeast Texas (DLM) to disclose my protected health information (PHI) with members of my family, a caregiver or a close friend for purposes such as the following:

- To make, change, or cancel an appointment
- To obtain test or lab results on my behalf
- To discuss my current health condition and/ or symptoms
- To pick up written prescriptions or pharmaceutical samples on my behalf
- To discuss my billing account
- Other: ____

In such circumstance, the following individuals are authorized to receive my PHI:

- ➢ ____
- ➢ ____
- ➢ ____

The following individuals are specifically NOT authorized to receive any of my PHI:

- ➢ ____
- ➢ ____
- ➢ ____

I understand that if information is requested via telephone, the caller may be asked to identify me by providing (a) my social security number and my date of birth as shown on DLM's records, and (b) the caller's full name shown above. If the request is made in person, the individual may be required to provide proper identification, including a photo ID. I understand that in order to add or delete designated people from the list, I must notify DLM in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to DLM.

____ _______/______/_______

Signature of Patient/ Legal Guardian Date

____

Printed Name

Dermatology & Laser Medicine
Of Southeast Texas
Sharon H. Marchand, MD

FINANCIAL POLICY

The office has contacts with five major insurance plans. Lease check with our reception staff to determine whether your pan is one of these.

If we have a contract with your plan, we will file a claim with your insurance company. The amount for which you are responsible (any deductibles, copays, percentages or non-covered services) is required at the time of service. We will check your benefits in advance of your visit in order to assure collection of the correct amount.

If you do not have one of the plans with which our practice is contracted, the total cost of your visit is required at the time of service; we will provide you with the necessary form to file your insurance claim.

If your insurance requires an authorization or referral, it is YOUR RESPONSIBILITY to ensure that our office receives the authorization or referral before the day of your visit.

If, at any time, you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you.

If you are unable to keep your scheduled appointment, we require a notice of at least 24 hours to allow us to accommodate another patient. Appointments not kept or cancelled without notice of 24 hours will result in a $35.00 No Show Fee.

For your convenience in paying, this office accepts Master Card, American Express, Visa, in addition to cash and checks.

If it becomes necessary to send your account for collections, your signature below indicates that you agree to pay all collection related charges.

I certify that I have read the financial policy of Dr. Sharon H. Marchand, M.D. and agree to abide by the policy.

Signature: ____ Date: ______________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _______________________________ **Date of Birth:** ______________________________

Phone: H): __________________________________ **Phone: W):** ________________________________

Address: ____________________________________ **City/State/Zip:** ____________________________

Please Note: *Copy Fee May Be Charged for Medical Records*

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _______________________________ **Facility Phone:** __________________________

Facility Address: _____________________________ **Facility Fax:** ______________________________

City, ST, Zip: __________________________________

Dates and Type of information to disclose:

☐ 2 years prior from last date seen

☐ Dates Other: ________________________

☐ Specific Information Requested: ____________________

The purpose of disclosure is:

☐ Change of Insurance or Physician

☐ Continuation of Care (e.g., VA Med Ctr)

☐ Referral

☐ Other________________________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: ____

Address: ____

City, State, Zip: ____

Fax: __________________________ **Phone:** ___________________

☐ **Please mail records.**

☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. **I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

____ ________________________________

Signature of Patient / Parent / Guardian or Authorized Representative **Date**

(Guardian or Authorized Representative must attach documentation of such status.)

____ ________________________________

Printed name of Authorized Representative **Relationship / Capacity to patient**

____

Address and telephone number of Authorized Representative