Bee Caves Dermatology – Patient Information 5300 Bee Caves Rd, Bldg 3, Ste. 120 Austin, Texas 78746
Phone 512-329-6090 Fax 512-329-0125

Patient Name: ____
(Last) (First) (Middle)

Address: ____
(Street, PO Box, apt #)

____
(City) (State) (Zip Code)

Home Phone :( )______________________Work Phone: ( ) ___________________

Cell phone: ( )____________________ **Email:** _____________________________

Date of Birth: ______________________ Social Security #________________________

Driver's License: State: ____________ #_______________________________________

Sex (Circle): Male / Female Marital status: ___________________

<u>Insurances Accepted: BCBS PPO, United Healthcare, Medicare Part B (Un-Assigned), Medicare Advantage Plans (Humana, UHC & BCBS) & Tricare Standard Plan</u>: Please give your CURRENT insurance card(s) & photo ID to the front desk and fill out the following information.

<u>PRIMARY INSURED / POLICY HOLDER INFORMATION</u>:

Occupation: _______________________ Employer: ___________________________

Billing Address: ____

Name / relation (spouse / parent): ____

Phone :( )___________ Date of birth: _________ Social Security# _______________

Primary Care Physician: ____

Medical References:

May we leave personal information on your voicemail at home? __Yes __No

On your cell? __Yes __No

May we leave test results with someone other than you, if so with whom?

____

Preferred Pharmacy: ____

<u>Emergency / Next of Kin Contact</u>:

Name and Relation: ____

Home phone ( ) ____________________Work phone ( ) _________________

<u>How did you hear about us?</u>

Referring Physician: ____________________________ **Internet Search / Website**

Friend/Family If yes, please list name ______________________

Insurance **Advertisement** (which one?) ___________________

ONLY COMPLETE THIS SECTION IF YOUR INSURANCE IS NOT LISTED ON THE FIRST PAGE

Fee for Service Patients Only: Patients with **NO HEALTH INSURANCE and/or** patients with **OTHER HEALTH INSURANCE** that Dr. Martinez is not a contracted provider with, **please read, check & sign below:**

_________ I have no medical insurance

_________ I have medical insurance with _________________________________ and Bee Caves Dermatology is not a participating provider with this company.

I understand that I will be required to pay in full for services provided to me by Bee Caves Dermatology at the time of service and that no insurance claim will be filed for me by Bee Caves Dermatology. I understand that I will be given a copy of the encounter form, and that I may file my own claim with my insurance company for potential reimbursement / credit for out of network deductibles for medical, non-cosmetic expenses only. I understand that Bee Caves Dermatology can make no estimate or guarantee as to what amount if any my insurance company may reimburse me. I understand that if I choose to supply Bee Caves Dermatology with my insurance information, this information may be entered for me for the purposes of non-cosmetic outside laboratory and pathology fees. However, Bee Caves Dermatology cannot be held responsible for those outside independent charges and cannot guarantee that my insurance company will cover those expenses.

X____

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

(The Privacy Notice can be reviewed on our website www.beecavesdermatology.com or upon check in at the office a copy can be made available to you)

By signing below, you acknowledge that you have been given the opportunity to review Bee caves Dermatology Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices if I desire. I understand that if I want to be seen as a patient by Dr. Martinez and her associates that this acknowledgement must be signed as required by law. I also consent to the use and disclosure of my medical information as set forth herein except as expressly stated below.

I hereby request the following **restrictions** on use and/or disclosure (specify as applicable) of my information:

____

____

____

Patient Name: ______________________________ Patient Date of Birth ___________

(Please Print Name)

Signatures:

Patient/Legal representative: ________________________________ Date: __________

If Legal representative, relationship to Patient:

____

Witness: ____ Date: _________

<u>Office Policies:</u> Please Read and Initial

_____ <u>Cancellation Notice:</u> **Please call and give us the courtesy of 24 hours business day advance notice for any cancellation. If you fail to give 24 hour notice for cancellation on 2 occasions, ("same day cancellation") the office will no longer schedule you appointments.**

_____ <u>**Failure to keep scheduled appointments "No Shows":**</u> **If you miss 2 or more appointments without prior notification, the office will no longer schedule you appointments.**

_____ <u>Minor patients:</u> A minor must be accompanied by parent or legal guardian or Bee Caves Dermatology must have written consent to see the unaccompanied minor. **A minor consent form is available on our website, www.beecavesdermatology.com**

_____ <u>Late to appointments:</u> If you are late for an appointment, you may be asked to reschedule or you may be asked to wait to be seen until all other patients that are on time are seen first. If you are late to 3 appointments the office may not schedule you any additional appointments.

_____ <u>Prescription Refills:</u> Please contact your pharmacy to initiate a refill on your prescription. The pharmacy will send a fax with all of the current prescription information for Dr. Martinez to approve or deny. Regular follow up appointments must be kept in order to maintain your current medications.

_____ <u>Financial policy for patients with BCBS, United Healthcare, Medicare Advantage Plans & Tricare Standard: we will file your claim for you.</u> However, if payment is not received from your insurance company, **you are ultimately responsible for any charges and you will be sent a bill for the charges. Patient statements are sent out monthly. Payment is due when you receive your statement. If no payment is received within 60 days, your account will be automatically turned over to a collection agency. If your insurance company is requesting information from you to process your claim please contact them immediately to avoid your account being turned over to collections. We do not accept assignment on the Traditional Medicare plan, you will be responsible for the limiting charge at the time of service, we will file to Medicare and any money due back to you will come from Medicare or your secondary/ supplement plan.**

_____ <u>Co-Pays and Deductible amounts are due in full at the time of service.</u> Insurance deductibles and co-pays are full responsibility of the patient. Please check with your insurance plan for your personal deducible and surgical deductible amount. Dr. Martinez is a specialist and may have higher co-pays than your primary care doctor.

I have read and understand the above office policies and agree with their terms. I understand that I have provided all appropriate insurance information, if Bee Caves Dermatology is filing my insurance. I understand that I am ultimately responsible for all charges whether paid for by insurance or not.

Signature ____________________________________ **Date** _______________________

Revised 3/2/2016 BCD

BEE CAVES DERMATOLOGY --PATIENT MEDICAL INFORMATION FORM

Patient Name: ____

(Last) (First) (Middle)

Male / Female? (Circle one)

Referring Physician: ______________________________________

Current or past medical problems: Have you had or do you have problems with any of the following?

Please circle if yes and explain	**If YES, what body part and date**
Skin cancer	
Basal cell carcinoma	______________________________
Squamous cell carcinoma	______________________________
Melanoma	______________________________
Abnormal moles (that had to be removed?)	______________________________

Please circle if yes

Cold sores

Hepatitis (A B C) other liver disorder

HIV

High blood pressure

Diabetes

Cholesterol, triglycerides

Kidney disorder

Thyroid disorder

Psychological disorder / depression

Artificial heart valve

Artificial joint

Blood or bleeding disorder

Other cancer ____________________

Heart

Lungs

Headache / seizure / neurologic disorder

Immune/autoimmune disorder/lupus

Stomach/ bowel/pancreas disorder

Bladder problems

Females - Are you pregnant? Yes / No

Planning to become Pregnant? Yes, when?______No

Last menstrual period____________________

Skin Cancer Risk

Do you use sun screen yes / no

Do you use a tanning bed yes / no

Have you had a bad blistering sunburn yes / no

Do you do high sun exposure activities like golfing, tennis, lake / water sports yes / no

Do you work outside yes / no

Surgical History: Please list any major surgeries you have had in the past:______________________

____

Medication Allergies and Reaction:

____

____

Current Medications:

____

____

Family Medical History: Has anyone in your immediate family had problems with:

Melanoma Yes / No Nonmelanoma skin cancer Yes/ No Abnormal moles? Yes/No

Social History: Do you drink alcohol? Yes/ No Do you smoke/ use other tobacco products?(dip,snuff) Yes/No

Do you or have you ever used IV drugs? Yes/ No

Sexual History: Are you sexually active? Yes/ No Have you ever had any sexually transmitted disease? Yes/No

If yes what type?______________