Bee Caves Dermatology – Patient Information 5656 Bee Caves Rd, Bldg. D, Ste. 203 Austin, Texas 78746
Phone 512-329-6090 Fax 512-329-0125 or E-fax 877-796-4414

Patient Name: _____
(Last) (First) (Middle)
Address: _____
(Street, PO Box, apt #)
_____
(City) (State) (Zip Code)
Home Phone :(__)_____Work Phone: ( ) _____

Cell phone: (_)_____ **Email:** _____

Date of Birth: _____ DL# & State _____

Sex: Male Female Marital status: _____

Insurances Accepted: BCBS PPO, Medicare Part B, Medicare Advantage Plans (Humana, BCBS, we are not in network for all UHC Medicare Advantage plans) Tricare Standard Plan, Scott & White (not all plans), Sendero, Ambetter, Oscar, SANA, Friday: Please give your CURRENT insurance card(s) & photo ID to the front desk and fill out the following information.

PRIMARY INSURED / POLICY HOLDER / GUARANTOR INFORMATION:
Name & Relation: _____
Billing Address (if different from above): _____
_____
Phone: _____ Date of Birth: _____

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 Appointment Reminder: ___ Phone ____Text ____Email ____None

Preferred Pharmacy & Location: _____

Emergency / Next of Kin Contact:
Name and Relation: _____ Phone: _____

How did you hear about us?

Referring Physician: _____ Internet Search Website Insurance

Friend/Family If yes, please list name _____

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_____

Privacy Practices Acknowledgement and Receipt

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be completed and **updated annually** by the patient or guardian:

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give **Bee Caves Dermatology and employees** my permission to discuss freely my condition, treatment or diagnosis with that person present.

(Circle one) YES NO

Notice of Privacy Practice:

By signing below, I acknowledge that I have been provided a copy of Bee Caves Dermatology's Notice of Privacy Practices Form for review and a personal copy to keep will be provided upon request. Bee Caves Dermatology's Notice is available on the practice's website www.beecavesdermatology.com and a copy can be obtained in office as well.

Signature of Patient or Guardian: _____ Today's Date _____

Relationship to Patient: Self Parent Legal Guardian

Personal Health Information (PHI)

This information must be completed and **updated every 6 months** by the patient or guardian

This release authorizes **Bee Caves Dermatology** to discuss medical information regarding my care, condition, treatment, or diagnosis with the following:

_____ Patient Only

_____ Spouse (Specify Name of Spouse): _____

_____ Parent(s) (Specify Name of Parent(s): _____

_____ Other (Please Specify): _____

Signature of Patient or Parent/Guardian: _____ Date: _____

Relationship to Patient: Self Parent Guardian

Patient Name: (please print) _____ Date of Birth: _____

Office Policies: Please Read and Initial

_____ **Cancellation Notice: Please call and give us the courtesy of 24 hours business day 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 your appointments.**

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

_____ Minor patients: 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**

_____ Late to appointments: 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.

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

_____ Financial policy for patients with BCBS PPO, Medicare Part B, Medicare Advantage Plans, Sendero, Ambetter, Scott & White, Tricare Standard, Oscar, SANA, & Friday Health Plan, we will file your claim for you. 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.**

_____ Co-Pays and Deductible amounts are due in full at the time of service. Insurance deductibles and co-pays are full responsibility of the patient. Please check with your insurance plan for your personal deductible 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 8/2022 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 No
Last menstrual period_____

Skin Cancer Risk

Do you use sunscreen 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

Have you been vaccinated for COVID-19?
Yes ____
No ____

Height _____ inches
Weight _____ lbs.

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? 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? _____