DERMATOLOGY CENTER of MCKINNEY

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES:

My signature below indicates that I have received and reviewed a copy of my physician's **Notice of Uses**, Disclosures of Protected Medical Information **(Notice of Privacy Practices),** and Payment Policy. I have been given the option of signing a separate Patient Consent Form.
Patient or Responsible Party Signature: _____ Date ____/_____/_____

Patient Consent Forms

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Use of prescribed medication
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees
- I authorize the Dermatology Center of McKinney and Dr. James Ralston, MD to take medical photographs of myself or my child (or person of whom I am a legal Guardian). I understand that the information will be used to enhance my medical records.

RX history consent: By signing the consent form I am agreeing that the Dermatology Center of McKinney and Dr. James Ralston can request and use my prescription medication history for other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. Understanding all of the above, I hereby provide informed consent to Dermatology Center of McKinney and Dr. James Ralston to enroll me in the e-Prescribe Program as described in the Notice of Privacy Practices

- I fully understand that this is given in advance of any specific diagnosis or treatment.
- I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
- I understand that **Dermatology Center of McKinney/James P. Ralston, M.D.**, may include consent at satellite offices under common ownership.
- I, the undersigned, authorize **Dermatology Center of McKinney/James P. Ralston, M.D.**, to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.
- A photocopy of this consent shall be considered as a valid as the original.

Patient Portal Consent: I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its Intermediaries for my claims. I assign the benefits payable for services to Dermatology Center of McKinney/James P. Ralston, M.D.

I acknowledge that I have been given the **Dermatology Center of McKinney/James P. Ralston, M.D.**, Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact James P. Ralston, M.D. **Patient Initials: _____**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature (or Responsible Party) _____ Date: ___/ _____/ _____

DERMATOLOGY CENTER of MCKINNEY

Patient Information

Please present your insurance card(s) and Photo ID to the receptionist along with this Completed form, Thank you.

☐ New Patient	☐ Name Change	☐ Address Change	☐ Insurance Change	Today's Date:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	Date of Birth	Sex (Male/Female):
Address:	City: State:	Zip Code:
Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Black/African American ☐ White ☐ Hispanic ☐ Other		
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Language: ☐ English ☐ Spanish ☐ Other	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Home #: ( ) Work #: ( ) Cell #: ( )		

PARENT, SPOUSE, OR RESPONSIBLE PARTY (*if different from patient*)

Last Name: First: Middle:	Date of Birth	Sex (Male/Female):
Address:	City: State:	Zip Code:
Home # ( ) Work # ( ) Cell # ( )		

INSURANCE COVERAGE (PRIMARY)

Insurance Company Name:	Policy Type: ☐ HMO ☐ PPO ☐ HSA ☐ Other: _____
Member ID #:	Group #:
Address of Claim Center:	City: State: Zip Code:
Customer Service #: ( )	Providers # (if different): ( ) Fax #: ( )
Name of Policy Holder (Insured):	Policy Holder's (Insured) Date of Birth:
Relationship to Insured: ☐ Mother ☐ Father ☐ Spouse ☐ Other _____	
Please check one: I have paid my insurance deductible for the calendar year _____ ☐ Yes ☐ No ☐ Don't know	

INSURANCE COVERAGE (SECONDARY)

Insurance Company Name:	Policy Type: ☐ HMO ☐ PPO ☐ HSA ☐ Other: _____
Member ID #:	Group #:
Address of Claim Center:	City: State: Zip Code:
Customer Service #: ( )	Providers # (if different): ( ) Fax #: ( )
Name of Policy Holder (Insured):	Policy Holder's (Insured) Date of Birth:
Relationship to Insured: ☐ Mother ☐ Father ☐ Spouse ☐ Other _____	

DERMATOLOGY CENTER of MCKINNEY

PATIENT MEDICAL HISTORY

Please Print

Today's date:			Primary Care Physician:	
Patient's last name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.	First:	Middle:	Date of Birth	SS#:

EMERGENCY CONTACT INFORMATION

Emergency Contact's Name:		Relationship to Patient:
Home #: ( )	Cell #: ( )	Work #: ( )

PRIVACY INFORMATION

I GIVE YOUR OFFICE PERMISSION TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING FAMILY MEMBERS:

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

May we leave personal medical information on your answering machine or cell phone: ☐ **YES** ☐ **NO**

Please register the following **email** for the Patient Portal and newsletter:

MEDICAL QUESTIONNAIRE

In order to help your physician better assess your medical problem and make appropriate treatment recommendations, we ask that you fill out this medical questionnaire. This is an important part of your medical evaluation and your physician will use this form as a guide for a more detailed medical history.

GENERAL

Briefly state what symptoms you are experiencing which prompted you making an appointment, and indicate how long you have had these symptoms

Symptom:	Duration:

Have you had this skin problem before: ☐ Yes ☐ No	What makes it better:	What makes it worse:

Are you being treated/followed for any other medical problems?

ALLERGIES AND MEDICATIONS

Drug Allergies:	Food Allergies:

Other Allergies:

Present Medications (include over-the-counter & herbal supplements/vitamins)

Name	Dose	How Often
1.		
2.		
3.		
4.		
5.		
6		
7.		

Preferred Pharmacy Name:	**Pharmacy Location:**

Patient's Name:	Date of Birth:

DO YOU HAVE NOW, OR HAVE YOU EVER HAD DISEASES OR CONDITIONS OF (PLEASE BUBBLE-IN EACH CIRCLE COMPLETELY):

	Yes	No		Yes	No		Yes	No
Basal Cell Carcinoma	O	O	Emphysema	O	O	High blood pressure	O	O
Squamous Cell Carcinoma	O	O	Heart attack	O	O	Lupus	O	O
Melanoma	O	O	Hepatitis B	O	O	Liver disease	O	O
Asthma	O	O	Hepatitis C	O	O	Psoriasis	O	O
Cancer:_____	O	O	HIV or AIDS	O	O	Rosacea	O	O
Diabetes	O	O	Herpes	O	O	Other:_____	O	O
Eczema	O	O	Kidney disease	O	O	_____		

SURGICAL PROCEDURES

Type of Operation:	Year:

FAMILY HISTORY

Have you had any family members with the following skin conditions?

	Melanoma	Basal Cell Carcinoma	Squamous Cell Carcinoma	Eczema	Psoriasis	Acne
Father	O	O	O	O	O	O
Mother	O	O	O	O	O	O
Siblings	O	O	O	O	O	O
Children	O	O	O	O	O	O

Any other family health conditions:

SOCIAL HISTORY

Occupation:	Hobbies:	Recent Travel: O Yes O No Where?
Tobacco Use: O Yes O No	Drink Alcohol: O Yes O No How much?	Do you wear sunscreen daily? O Yes O No

REVIEW OF SYSTEMS

Have you developed any other problems with other body systems associated with your skin problems (specify problem)?

	Yes	No		Yes	No
Pregnant	O	O	Enlarged lymph nodes	O	O
Trying to become pregnant	O	O	Suppressed immune system	O	O
Breastfeeding	O	O	Keloids	O	O
Allergic to antibiotic ointments	O	O	Pacemaker/defibrillator	O	O
Allergic to bandages and tapes	O	O	Sensitivity to sunlight	O	O
Daily asprin/blood thinner	O	O	Prosthetic joint(s)	O	O
Easy bruising or bleeding disorder	O	O	Recent weight change	O	O
Difficulty healing	O	O	Have you ever used Tanning Beds	O	O

Patient Signature:	Today's date: