

# Sonterra Dermatology PATIENT INFORMATION

(Please Print Clearly)

Today's date:

PATIENT INFORMATION			
Patient's Name:			Sex: M____ F____
Social Security #:		Birth date: / /	Age:
Street address:		Minor____ Single____ Married____ Widowed____ Other____	
P.O. box:	City:	State:	ZIP Code:
Home Phone ( )	Work Phone ( )	Ext:	Cell Phone ( )
Occupation:	Employer:	Student: FT____ PT____	
Race:	Ethnicity:	Language:	
Referred by:	Other family members seen here:		

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:		Address (if different):	Home phone : ( )
Birth date: / /	Drivers License #:	Social Security #:	
Address:	City:	State:	ZIP Code

### PRIMARY INSURANCE

Name of insured:	Social Security #	Birth date: / /	Group Number:	ID Number:
Employer			Name of Insurance	

### SECONDARY INSURANCE

Name of insured:	Social Security #	Birth date: / /	Group Number:	ID Number:
Employer			Name of Insurance	

### IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Work phone : ( )
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**PAYMENT POLICY:** All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite payment reimbursement from private carriers.

**AUTHORIZATION OF PAYMENT:** I hereby authorize the provider to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

## MEDICAL QUESTIONNAIRE

Name: \_\_\_\_\_  
Referred by: Dr. (Name) \_\_\_\_\_  
Friend (Name) \_\_\_\_\_  
Newspaper \_\_\_\_\_  
Website \_\_\_\_\_

Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Family Member (Name) \_\_\_\_\_  
Yellow Pages \_\_\_\_\_  
Other \_\_\_\_\_

### Medical History:

Reason for visit: \_\_\_\_\_

How long have you had this problem: \_\_\_\_\_

Symptoms (How does it bother you?): \_\_\_\_\_

Treatments you have tried: \_\_\_\_\_

Please list all medications you are taking including over the counter: \_\_\_\_\_

Please list any drugs you are allergic to: \_\_\_\_\_

### Medical Problems (Check if yes)

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Artificial Joint/valve | <input type="checkbox"/> Anemia                | <input type="checkbox"/> X-Ray Therapy      |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hepatitis, type _____ | <input type="checkbox"/> Lupus              |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Other Lung Disease     | <input type="checkbox"/> Other Liver Disease   | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Thyroid Disease        | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Cancer, type _____ |
| <input type="checkbox"/> Other _____         |   | <input type="checkbox"/> Long-term steroid use |   |

### Past surgeries/medical problems: \_\_\_\_\_

Pregnant?  Yes  No ( \_\_\_\_\_ weeks, # previous pregnancies \_\_\_\_\_ )

History of skin cancer?  Melanoma  Basal cell carcinoma  Squamous cell carcinoma

Area of body: \_\_\_\_\_ How treated: \_\_\_\_\_

History of skin disease, past or current: \_\_\_\_\_

When you are exposed to sunlight do you: (Check most applicable)

- |   |   |
|---|---|
| <input type="checkbox"/> Always burn              | <input type="checkbox"/> Sometimes burn, tan well |
| <input type="checkbox"/> Usually burn, rarely tan | <input type="checkbox"/> Rarely burn, always tan  |
| <input type="checkbox"/> Often burn, tan slowly   | <input type="checkbox"/> Never burn, deeply tan   |

### Review of symptoms: (Please mark which of the following symptoms you are currently having)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Prone to infection  | <input type="checkbox"/> Vision                | <input type="checkbox"/> Hearing            | <input type="checkbox"/> Stuffy Nose               |
| <input type="checkbox"/> Weight change       | <input type="checkbox"/> Eyelid scale          | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Sinus pain                |
| <input type="checkbox"/> Fever/sweats        |  | <input type="checkbox"/> Faint              | <input type="checkbox"/> Mouth sore/throat pain    |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Nausea/vomiting    | <input type="checkbox"/> Penile/vaginal pain       |
| <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Cough/wheezing        | <input type="checkbox"/> Abdomen pain       | <input type="checkbox"/> Penile/vaginal discharge  |
|  |  | <input type="checkbox"/> Bowel changes      | <input type="checkbox"/> Menstrual irregularity    |
| <input type="checkbox"/> Lymph node swelling | <input type="checkbox"/> Weakness of body part | <input type="checkbox"/> Joint/muscle pain  | <input type="checkbox"/> Painful urination         |
| <input type="checkbox"/> Easy bleeding       | <input type="checkbox"/> Numbness of body      | <input type="checkbox"/> Back pain          | <input type="checkbox"/> Change in urination freq. |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Rash                | <input type="checkbox"/> Itchy skin            | <input type="checkbox"/> Skin growths       | <input type="checkbox"/> Bad scars (keloids)       |
| <input type="checkbox"/> Dry skin            | <input type="checkbox"/> Skin sores            | <input type="checkbox"/> Hair/nail problems | <input type="checkbox"/> Skin color changes        |

### Past Family and Social History:

Is there family history of (please circle): melanoma, skin cancer, asthma, exzema, hay fever, psoriasis, hair loss, diabetes, adult acne, genetic diseases? Other: \_\_\_\_\_

Patient occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Animals in home? \_\_\_\_\_ If smoker, how many packs/day for ? years: \_\_\_\_\_

Number of alcoholic drinks per week: \_\_\_\_\_

History of past IV drug abuse, blood transfusions, or unprotected intercourse:  Yes  No Reviewed by MD \_\_\_\_\_

# Sonterra Dermatology

325 E Sonterra Blvd., Suite 110, San Antonio, TX 78258

Office: 210-496-5792; Fax: 210-496-7601

Please list the family members or other persons, if any, with whom we may discuss your general medical condition and/or your diagnosis:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please print the telephone number where you want to receive calls about appointments, lab or test results, billing, insurance inquiries, or other health care information:

Phone (     ) \_\_\_\_\_ - \_\_\_\_\_

May confidential messages such as appointments, lab or test results, billing, insurance inquiries be left on the answering machine or voicemail at the telephone number provided here?

YES \_\_\_\_\_ NO \_\_\_\_\_

**I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect any actions that Sonterra Dermatology took before receiving my revocation.**

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature if under 18 years of age

\_\_\_\_\_  
Date

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I acknowledge that I have received a brochure providing the following information and have been given the opportunity to read and ask questions to assure that I understand their contents. I understand that by signing this form, I consent to the provisions of my patient rights, patient responsibilities and the sharing of information as indicated by the Notice of Privacy Practices

- **Notice of HIPAA Privacy Practices**
- **Patient Responsibility**
- **Patient Rights Regarding Health Information**

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Patient or Legal Representative Signature

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Date

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Guardian Signature if under 18 years of age

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Date