



**EVANS**  
DERMATOLOGY  
PARTNERS

## NEW PATIENT FORMS & INFORMATION

Welcome to Evans Dermatology Partners.

This new patient paperwork, will help us get to know you a bit better at your first appointment. You may complete these forms by hand, or fill them in electronically and bring them to your appointment.

Please bring the following items with you to your first appointment:

- Completed New Patient forms
- Insurance card(s)
- List of all current over-the-counter and prescription medicines
- Co-payment. We accept cash, check, debit or Visa/Mastercard/Amex/Discover
- Parent or guardian must accompany all patients under 18 years old. Caretaker must accompany incapacitated patients.



## OUR LOCATION

Near the intersection of Brodie & Slaughter, just north of the Randall's shopping plaza and Goodwill on Brodie Lane.

9701 Brodie Lane, Suite 106  
Austin, TX 78748

(512) 280-3939  
[appointments@evans-dermatology.com](mailto:appointments@evans-dermatology.com)  
[www.evans-dermatology.com](http://www.evans-dermatology.com)

# NEW PATIENT REGISTRATION FORM

## PATIENT'S PERSONAL INFORMATION

\_\_\_\_\_ **Sex**  M  
\_\_\_\_\_  F  
First Name Middle Last Name Nickname

**Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YY

**Marital Status**  Single  Married  Divorced  Widowed

**Race**  White  African American  Asian  Other \_\_\_\_\_  Decline

**Ethnicity**  Non-Hispanic  Hispanic  Other \_\_\_\_\_  Decline

**Preferred Language (if other than English)** \_\_\_\_\_

### Address

\_\_\_\_\_ Street Apt City State Zip

### Phone Numbers

**Home** ( ) \_\_\_\_\_ **Cell** ( ) \_\_\_\_\_ **Work** ( ) \_\_\_\_\_

**E-mail Address** \_\_\_\_\_

### Preferred Means of Communication

Home  Cell  Work  E-mail

## PERSON RESPONSIBLE FOR BILL

**Name** \_\_\_\_\_

### Relationship to Patient

Self  Spouse  Parent  Other

**Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YY

**Phone** ( ) \_\_\_\_\_

**Address** \_\_\_\_\_ Street Apt City State Zip

## PRIMARY MEDICAL INSURANCE

**Insurance Co.** \_\_\_\_\_

**Employer** \_\_\_\_\_

**Policyholder's Name** \_\_\_\_\_

### Relationship to Patient

Self  Spouse  Parent  Other

**Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YY

## SECONDARY MEDICAL INSURANCE

**Insurance Co.** \_\_\_\_\_

**Employer** \_\_\_\_\_

**Policyholder's Name** \_\_\_\_\_

### Relationship to Patient

Self  Spouse  Parent  Other

**Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YY

## PRIMARY CARE PHYSICIAN

**Full name** \_\_\_\_\_

**Did this doctor refer you to us?**  Yes  No

## PREFERRED PHARMACY

**Name** \_\_\_\_\_ **Address** \_\_\_\_\_  
(or intersection)

## EMERGENCY CONTACT

**Name** \_\_\_\_\_ **Relationship to Patient**  Spouse  Parent  Child  Other **Phone** ( ) \_\_\_\_\_



# ACKNOWLEDGEMENT OF OFFICE POLICIES

## Insurance Filing Authorization

I certify that the information contained in my registration and health history forms is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Evans Dermatology Partners. I also authorize Evans Dermatology Partners or insurance company to release any information required to process my claims. I agree that a photocopy or scan of this agreement shall be as valid as the original.

## Notice of Privacy Practices

I have read a copy of Evans Dermatology Partner's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I authorize the release of any medical information necessary to evaluate or treat my condition. I further authorize the release of any medical information necessary to process insurance claims on my behalf. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

## Payment Policies

Payment is due at time of service. This amount includes any co-pay as well as the amount of outstanding insurance deductible or co-insurance. I understand that I am financially responsible for all charges for services rendered on my behalf or on behalf of my dependant, whether or not they are covered by my insurance.

## Cancellation Policy

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel at least 24 hours prior to the scheduled appointment. Evans Dermatology Partners reserves the right to charge the patient a \$50 fee if the patient does not cancel the appointment at least 24 hours in advance. Additionally, Evans Dermatology Partners reserves the right to reschedule appointments to which the patient is more than 30 minutes late.

## Formulary Benefits and Prescription History

Formulary Benefits data are maintained by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. By signing below I give permission for Evans Dermatology Partners to attempt to obtain prescription benefits data electronically and, if possible, to download a historic list of all medications prescribed for me by any medical provider.

## E-mail Communication

Evans Dermatology Partners will not share your email address with any third parties without your consent.  
 I prefer NOT to receive periodic marketing updates from Evans Dermatology Partners via email.

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Parent/Guardian's Name** \_\_\_\_\_  
(if applicable)

**Signature** \_\_\_\_\_

# PERSONAL HEALTH HISTORY

*All answers are confidential*

**PATIENT NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**TODAY'S DATE** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **REASON FOR VISIT** \_\_\_\_\_

## MEDICAL HISTORY

### Allergies to medications

**NONE**

**Name of the drug**

**Reaction you had**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current medications, incl. over-the-counter drugs, vitamins & supplements

**NONE**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Have you ever had any of the following?

	Yes	No	If yes, please explain
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Seasonal <input type="checkbox"/> Skin <input type="checkbox"/> Other
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Type I <input type="checkbox"/> Type II
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Unknown
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Basal Cell <input type="checkbox"/> Squamous Cell <input type="checkbox"/> Melanoma <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_ / \_\_\_ / \_\_\_

**Any other medical problems that other doctors have diagnosed?**

\_\_\_\_\_  
\_\_\_\_\_

**Surgeries**  **NONE**

Year	Reason	Year	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY**

**Has anyone in your family ever had:**

	Yes	No	Relationship	
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Basal Cell <input type="checkbox"/> Squamous Cell
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Melanoma <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Other skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Description _____

**HEALTH HABITS**

**What is your occupation?** \_\_\_\_\_

	Yes	No	Former User	
Do you use a tanning bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many times per week? _____
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many packs per day? _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many drinks per week? _____
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what type? _____

**FEMALE PATIENTS ONLY**

Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Using contraception?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			If yes, what type?	_____	
Breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	Trying to get pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

**COSMETIC CONCERNS (optional)**

Some of our patients would like more information about the cosmetic treatment of sun damage and aging skin. Do you have any cosmetic concerns you would like to discuss?  Yes  No

**MESSAGES REGARDING LAB/PATHOLOGY RESULTS**

When we are unable to reach you directly regarding benign/normal lab or pathology results, we typically leave a voicemail or answering machine message with the result(s). The decision about whether to leave a detailed message is at the discretion of the staff of Evans Dermatology.

I DO NOT want to receive any results on my voicemail or home answering machine. Please ONLY leave callback details.



## AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I hereby authorize the physicians and staff of Evans Dermatology Partners to disclose any and all details of my medical diagnoses, treatment and billing/claims information to the following individuals:

Name	Relationship	Phone
_____	_____	( ) _____ - _____
_____	_____	( ) _____ - _____
_____	_____	( ) _____ - _____

I elect not to authorize disclosure to any individuals at this time

This authorization is voluntary and I understand that I have the right to revoke this authorization by submitting a written request to the office manager for Evans Dermatology Partners. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the above list may not be exhaustive and that my protected health information may be disclosed to additional individuals based on my verbal authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**



## Auto Bill Pay (optional)

**EVANS**  
DERMATOLOGY  
PARTNERS

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Some of our patients find it convenient to leave a credit card number on file so that their out-of-pocket balances can be charged automatically.

We will always ensure that your claim has been processed by insurance before charging the portion designated by your insurance as "patient responsibility".

Once we process any charges, a receipt will be e-mailed (if we have an e-mail address on file) or a paper copy of the receipt will be mailed to you.

### Please automatically charge:

- Full balance due
- Balances of \$50 or less

**Card Holder Name:** \_\_\_\_\_

**Credit Card Number:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**Security Code:** \_\_\_\_\_

(3-digit code on the back of your Visa or MC or 4-digit code on the front of your Amex)

**Billing Address:** \_\_\_\_\_

(If different from patient)

**Signature:** \_\_\_\_\_