Donald J. Brown, D.O.
Bayside Dermatology, P.A.

PATIENT INFORMATION

LAST:_____ FIRST: _____ MI: _____

ADD: _____ CITY: _____ STATE: _____ ZIP:_____

~~SS~~# _____-____-_____DOB: _____-____-____ AGE: _____ MALE___FEMALE ___

Circle: SINGLE MARRIED DIVORCED WIDOWED STUDENT

HM PHONE: (_____) _____-_____ CELL: (_____) _____- _____

EMPLOYER:_____PH: (____) ____-_____ Occupation: _____

INSURANCE:_____ SECONDARY: _____

Policy Holder if other than patient:

NAME:_____ DOB: _____ ~~SS~~#_____-_____- ____

EMERGENCY CONTACT:_____ PH# (____) ____- _____

PERSONAL CARE PHYSICIAN:_____ PHARMACY: _____

Who recommended you to Dr. Brown: _____

MEDICATION ALLERGY:_____

MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

Describe any medical treatments you are currently being treated for:_____

_____

Please check the following conditions that apply:

___ Bleeding Problems	___ Implants	___ Cancer _____	___ Coumadin
___ Heart Problems	___ Grafts/Transplant	___ History Skin Cancer	___ Hepatitis
___ High Blood Pressure	___ HIV / AIDS	___ History Melanoma	___ Family HX skin cancer
___ Kidney Disease	___ Immunodeficiency	___ Skin Cancer	___ Mental Problems
___ Asthma	___ Daily alcohol use	___ Daily Tobacco use	___ Ulcer
___ Diabetes	___ Other _____		

Consent for treatment, release of information and payment of benefits. *If your insurance requires a referral you must obtain from your PCP before your visit or we will have to reschedule due to your insurance will not pay without a valid referral.* By signing this document I, hereby authorize Dr. Donald J. Brown / Bayside Dermatology, P.A. give consent to treat my condition as deemed medically necessary and file insurance as a courtesy on your behalf and benefits are assigned to us. Co-pay, Deductible and Co-insurance is due at the time of visit. We comply with all HIPPA laws and regulations to protect your health information. We do abide by all HIPPA laws and guidelines.

Signature:_____ Date: _____

E-MAIL: _____

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Financial Agreement

Medical Insurance- As a courtesy to you we will file your insurance claim. We cannot guarantee payment from your insurance carrier. You are responsible for co-pays, deductibles and services denied or not covered by your insurance. If your insurance requires a referral you are responsible for obtaining that from your Primary Care Doctor.

Co-Pay- This is an amount set by your insurance carrier to access medical care according to your contract with your insurance and must be paid at time of visit. We cannot waive Co-pays due to our contract with your insurance carrier.

Deductible- This is the out of pocket amount you must pay before your insurance carrier will pay for covered services. Most insurance carriers start the deductible over January 1. Medicare has a $283.00 yearly deductible. We cannot write off deductibles due to our contract with your insurance carrier.

Payment- If we are filing your insurance we will obtain benefits and if any co-insurance or deductible are due we will collect that amount at time of service.
Payment options are: cash, check or credit card (i.e.; American Express, Discover, MasterCard and Visa).

Missed Appointment Fee- Our office requests at least 24 hour notice if you are unable to keep your appointment. If less than 24 hour notice is given or appointment is missed a $25.00 fee will be charged. If three (3) appointments are missed you may be dismissed from this practice.

Return Check Fee- $35.00 fee for returned checks

Monthly Statements- If you have a balance you will be sent a statement and is payable upon receipt. We do not carry balances. If your account becomes past due your account may be turned over to a collection agency for further attempts to collect a debt.

Assignment and Release of Insurance Benefits:

In order for our office to bill your insurance on your behalf, by assigning and releasing benefits directly to Bayside Dermatology - Donald J. Brown, DO, if any, otherwise payable to me for services rendered. I understand that for any reason my insurance does not pay I am responsible for services rendered. I hereby authorize the doctor to release any or all information necessary to obtain payment from your insurance carrier. I authorize the use of this signature on all insurance submissions.

Date

Signature / Legal Guardian

Donald J. Brown, D.O.
Bayside Dermatology, P.A.

1321 WATERS EDGE DRIVE SUITE 1006
GRANBURY, TEXAS 76048
817-573-1800

HIPPA Privacy Consent

I, _____ , give Bayside Dermatology, P.A. my consent to use or
Print Name
disclose my protected health information to carry out my treatment, including providing my records to another physician if I am referred and to obtain payment from insurance companies and for health care operations (i.e., quality reviews).

I have been informed that I may review the Notice of Privacy Practices of this clinic for a more complete description of uses and disclosures before signing this consent.

I understand that Bayside Dermatology, P.A. has the right to change our policy practices and that I may obtain such revised notices upon request.

I also understand that I may revoke this consent at any time, by making a written request.

If patient is a minor, once established, I will allow them to be seen without the accompaniment of a parent or legal guardian.
_____ YES _____No

Who is your Primary Care Physician: _____

Has any of your information changed? ____Yes ____No
***If so please update below:**

____ INSURANCE _____

____ ADDRESS _____

____ PHONE HOME(____) _____-_____ CELL (____) _____-_____

____ Emergency Contact _____ Phone (____) _____-_____

***Please list anyone who we may release your information to:
(if spouse, relative or friend is not listed below we cannot release any information)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Signature: _____ Date: _____

Review of Systems: Are you **CURRENTLY** experiencing any of the following?
(please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
FEMALES ONLY – History of irregular menses		
Immunosuppression		
Hay fever		
Chest pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stool		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Other Symptoms: _____

Alerts: Do you currently have any of the following?
(please check yes or no for the following)

Alert	Yes	No
Pacemaker		
Defibrillator		
Allergy to lidocaine		
Allergy to topical antibiotics		
Rapid heart beat with epinephrine		
Premedication prior to surgery		
Artificial joints within the past 2 years		
Artificial heart valve		
History of MRSA		
Taking blood thinners		
Pregnancy or planning a pregnancy		
Allergy to adhesive		
Yeast infection with antibiotics		
GI "stomach" upset with antibiotics		
HIV/AIDS		
Hepatitis B		
Hepatitis C		
Allergy to latex		
History of tanning bed use less than 15 times		
History of tanning bed use greater than 30 times		
Height (approximately)	‘ “	
Weight (approximately)	lbs	
Ebola Risk: Fever >=100.4°(F)/38° (C)		
Ebola Risk: Resided or traveled to country with wide-spread Ebola transmission in the last 21 days		
Ebola Risk: Contact with an Ebola patient without proper protective equipment in the last 21 days		
Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage		

Other Symptoms: _____