



EVANS
DERMATOLOGY
PARTNERS

NEW PATIENT FORMS & INFORMATION

Welcome to Evans Dermatology Partners. We appreciate the trust you have placed in us and look forward to providing you with the highest quality patient care.

In this packet you will find our new patient paperwork, which 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.

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

- Completed forms contained in this packet
- Insurance card(s)
- Driver's License, or other photo ID
- List of all current over-the-counter and prescription medicines
- Co-payment. We accept cash, check, debit or Visa/Mastercard
- Parent or guardian must accompany all patients under 18 years old

Should you have any questions, please feel free to call (512) 280-3939 for assistance.



OUR LOCATION

We are located near the intersection of Brodie & Slaughter, just north of the Randall's shopping plaza and Goodwill on Brodie Lane.

9701 Brodie Lane, Suite A-106
Austin, TX 78746

(512) 280-3939

(512) 280-3938 - fax

www.evans-dermatology.com



NEW PATIENT REGISTRATION FORM

PATIENT'S PERSONAL INFORMATION

Name _____
First Name _____ Initial _____ Last Name _____ Prefer to be Called _____

Date of birth ____ / ____ / ____ Sex M F Social Security # ____ - ____ - ____
MM DD YY

Marital status Single Married Divorced/separated Widowed

Phone Numbers
Home () _____ Work () _____ Cellular () _____

Address _____
Street Apt City State Zip

E-Mail Address _____

PRIMARY MEDICAL INSURANCE

Insurance Co. _____

Policyholder: Name _____ Date of birth _____ SSN ____ - ____ - ____

Relationship Self Spouse Child Other Employer _____

SECONDARY MEDICAL INSURANCE

Insurance Co. _____

Policyholder: Name _____ Date of birth _____ SSN ____ - ____ - ____

Relationship Self Spouse Child Other Employer _____

PRIMARY CARE PHYSICIAN

Full name _____ Phone (if known) () _____

Did this doctor refer you? Yes No If no, how did you find us? _____

PREFERRED PHARMACY (if known)

Name _____ Address _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone 1 () _____ Phone 2 () _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Evans Dermatology Partners. 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. 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.

Signature of Patient (or Parent/Guardian)

Date



PERSONAL HEALTH HISTORY

All answers are confidential

PATIENT NAME _____ DATE _____

REASON FOR TODAY'S VISIT _____

MEDICAL HISTORY

Allergies to medications

Name of the drug

Reaction you had

Current medications, including over-the-counter drugs, vitamins & supplements

Any medical problems that other doctors have diagnosed

Have you ever had any of the following?

	Yes	No	If yes, please explain
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
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"/>	_____

Have you ever had any of the following?, continued

	Yes	No	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

Surgeries

Year	Reason
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Has anyone in your family ever had:

	Yes	No	Relationship	Type of cancer
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other serious medical problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Description _____

HEALTH HABITS

What is your occupation? _____

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

FEMALE PATIENTS ONLY

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

COSMETIC CONCERNS (optional)

Some of our patients have concerns about the appearance of their skin, if you would like to discuss any of the following with your doctor, please check below.

Lines and wrinkles	<input type="checkbox"/>	Discoloration	<input type="checkbox"/>
Sun damage	<input type="checkbox"/>	Age spots	<input type="checkbox"/>
Other: _____			



ACKNOWLEDGEMENT OF OFFICE POLICIES

Patient's Name: _____ **Date:** _____

Parent/Guardian's Name: _____
(if applicable)

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*.

Patient Signature (or parent/guardian) _____

PAYMENT POLICIES

Payment is due at time of service. This amount includes any co-pay as well as the amount of outstanding insurance deductible. 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.

Patient Signature (or parent/guardian) _____

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.

Patient Signature (or parent/guardian) _____