Patient Name: ____
(Last) (First) (Middle)

Address: ____
(Street, PO Box, apt #)

____
(City) (State) (Zip Code)

Home phone:( )______________________Work Phone: ( )___________________

Cell phone or pager : ( )____

Date of Birth:______________________ Social Security #________________________

Driver's License: State:____________ #_______________________________________

Sex (Circle) : Male / Female Marital status:____________________

Primary care provider ____

Referring physician:____

Employment information (If patient is a minor, please list the parent's /responsible party's employment information.)

Occupation:____

Employer Name :____

Employer Address:____

____

Employer Phone: ( )____

Emergency Contact:

Name and Relation:____

Home phone ( ) _______________________Work phone ( ) __________________

Address____

Contracted Insurance Patients: BCBS, Medicare, Medicare Advantage Plan Information: Please give your CURRENT insurance card (s) to the front desk and fill out the following information.

____Medicare only ____ Medicare with secondary Insurance____________________

____ Medicare Advantage Plan ____

____Blue Cross Blue Shield

Are you the PRIMARY INSURED / POLICY HOLDER?

Yes - please verify the above information is correct and initial here ______________

No - answer the following information about the policy holder:

PRIMARY INSURED / POLICY HOLDER INFORMATION:

Name / relation (spouse / parent): ____

Home address: ____

____

Phone:( )____

Date of birth:________________ Social Security #______________________________

Fee for Service Patients: Patients with NO **HEALTH INSURANCE &**/ or patients with **OTHER HEALTH INSURANCE** that Dr. Martinez is not a contracted provider with.

Please be aware that at this time, Dr. Martinez is ONLY a contracted provider with BCBS, Medicare, and several Medicare Advantage Plans. We are not contractors with any other plan and cannot file any other claims.

_________ I have no medical insurance

_________ I have medical insurance with _______________________________ and Bee Caves Dermatology is not a participating provider with this company. However, I want to see Dr. Martinez on a fee for service basis and I know that I am responsible for filing the claim if I choose to my insurance company. I understand that Bee Caves Dermatology cannot file the claim for me.

I understand that I will be required to pay in full for services provided to me by Bee Caves Dermatology at the time of service and that no insurance claim will be filed for me by Bee Caves Dermatology. I understand that I will be given a copy of the encounter form, and that I may file my own claim with my insurance company for potential reimbursement / credit for out of network deductibles for medical, non-cosmetic expenses only. I understand that Bee Caves Dermatology can make no estimate or guarantee as to what amount if any my insurance company may reimburse me. I understand that if I choose to supply Bee Caves Dermatology with my insurance information, this information may be entered for me for the purposes of non-cosmetic outside laboratory and pathology fees only. However, Bee Caves Dermatology cannot be held responsible for those outside independent charges and cannot guarantee that my insurance company will cover those expenses.

X____
Signature and date

Acknowledgement of Review of Notice of Privacy Practices (HIPAA): I have been given the opportunity to review Bee Caves Dermatology Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices if I desire. I understand that if I want to be seen as a patient by Dr. Martinez and her associates that this acknowledgement must be signed as required by law.

Signature____Date___________
(Patient or Personal Representative, if the patient is a minor or unable to sign themselves)

Office Policies: Please read and initial

_____ **Cancellation notice: If you need to cancel an appointment, we require 24 hour notice. If you do not give 24 hour notice, you will automatically receive a $25.00 missed appointment fee. There are no exceptions to this policy.**

_____ **Failure to keep scheduled appointments "No Shows": If you miss an appointment, you will receive a $25.00 missed appointment fee. If you miss 2 or more appointments without prior notification, the office will no longer schedule you appointments.**

_____ Minor patients: A minor must be accompanied by parent or legal guardian or have a written consent to see the unaccompanied minor .

_____ Late to appointments: If you are late for an appointment, you may be asked to reschedule or you may be asked to wait to be seen until all other patients that are on time are seen first. If you are late to 3 visits the office may not schedule you any additional appointments.

_____ Financial policy for patients with Medicare, BCBS, & Medicare Advantage Plans. If you have Medicare and a secondary insurance, Medicare only, or non-Medicare primary insurance that we are a contracted provider for – we will file your claim. However, if payment is not received from you insurance company, **you are ultimately responsible for any charges and you will be sent a bill for the charges. Patient statements are sent out monthly. Payment is due when you receive your statement. If no payment is received within 60 days, your account will be automatically turned over to a collection agency**

_____ Co-Pays and Deductible amounts are due in full at the time of service. Insurance deductibles and copays are the full responsibility of the patient. Please check with your specific insurance plan for your personal deductible and surgical deductible amount. Dr. Martinez is a specialist and may have a higher copay than your primary care doctor.

I have read and understand the above office policies and agree with their terms. I understand that I am ultimately responsible for all charges whether paid for by insurance or not.

Signature____Date_______

REVISED 1-2010 BCD

BEE CAVES DERMATOLOGY --PATIENT MEDICAL INFORMATION FORM

Patient Name: ____

(Last) (First) (Middle)

Male / Female? (Circle one)

Referring Physician: ____________________________

Current or past medical problems: Have you had or do you have problems with any of the following?

Please circle if yes and explain	**If YES, what body part and date**
Skin cancer	
Basal cell carcinoma	______________________________
Squamous cell carcinoma	______________________________
Melanoma	______________________________
Abnormal moles (that had to be removed?)	______________________________

Please circle if yes

Cold sores
Hepatitis (A B C) other liver disorder
HIV
High blood pressure
Diabetes
Cholesterol, triglycerides
Kidney disorder
Thyroid disorder
Psychological disorder / depression
Artificial heart valve
Artificial joint
Blood or bleeding disorder
Other cancer ___________________
Heart
Lungs
Headache / seizure / neurologic disorder
Immune/autoimmune disorder/lupus
Stomach/ bowel/pancreas disorder
Bladder problems

Females - Are you pregnant? Yes / No
Planning to become Pregnant? Yes, when?______No
Last menstrual period________________________

Skin Cancer Risk
Do you use sun screen yes / no
Do you use a tanning bed yes / no
Have you had a bad blistering sunburn yes / no
Do you do high sun exposure activities like golfing, tennis, lake / water sports yes / no
Do you work outside yes / no

Surgical History: Please list any major surgeries you have had in the past:___________________________
____

Medication Allergies and Reaction:
____
____

Current Medications
____
____

Family Medical History: Has anyone in your immediate family had problems with:
Melanoma Yes / No Nonmelanoma skin cancer Yes/ No Abnormal moles? Yes/No
Social History: Do you drink alcohol? Yes/ No Do you smoke/ use other tobacco products? (dip, snuff) Yes/No
Do you or have you ever used IV drugs? Yes/ No
Sexual History: Are you sexually active? Yes/ No Have you ever had any sexually transmitted disease? Yes/No
If yes what type? ________________