Dallas Center for Dermatology and Aesthetics
8201 Preston Road, Suite 350 Dallas, TX 75225
P: 214-631-SKIN (7546) F: 214-631-8546
Lori D. Stetler M.D., P.A. * Kristel D. Polder M.D., P.A. * Jill Feetham M.D.
Jennifer Scheiderich, P.A

PATIENT INFORMATION RECORD

Name: ______________________________ Date: ______________

Address: ____
STREET CITY STATE ZIP CODE

Home Ph: (____)____________ Work Ph: (____)____________ Cell Ph: (____)____________

Email Address: ______________________________

DOB: ____/____/____ Age: ______ ☐ Male ☐ Female Marital Status: ☐S ☐M ☐D ☐W

Employer: ______________ SS# ______-______-______ DL#______________

Preferred Communication: ☐ Home ☐ Work ☐ Cell ☐ Email

OPTIONAL PATIENT INFORMATION (please circle your selection)

Race: White / Black / African American / Other : ______________

Ethnicity: ☐Not Hispanic / Latino ☐ Hispanic / Latino

Primary Language: English / Spanish / Other: ______________

Spouse's Name: ______________ DOB: ___/___/___ SS #______-______-______

Spouse's Employer: ______________ Spouse's Work Ph: ______________

In Case of Emergency, Contact: ______________ Phone: (____)____________

Referred by: ( )Physician ( )Family Member ( )Friend ( )Website ( )Other: ______________

Preferred Pharmacy:______________ Ph#/Address: ______________

IF PATIENT IS A MINOR OR STUDENT

Mother's Name: ______________ DOB: ___/___/___ SS#: ______-______-______

Address: ____
STREET CITY STATE ZIP CODE

Home Ph: (____)____________ Work Ph: (____)____________ Cell Ph: (____)____________

Father's Name: ______________ DOB: ___/___/___ SS#: ______-______-______

Address: ____
STREET CITY STATE ZIP CODE

Home Ph: (____)____________ Work Ph: (____)____________ Cell Ph: (____)____________

INSURANCE

Insurance Company: ______________ Insured ID#: ______________

Insured Name: ______________(if different from patient) DOB:____/____/____

RELEASE AND ASSIGNMENT OF BENEFITS: I hereby authorize the release of any & all medical information to my insurance carrier(s) or their representative, for purposes necessary in the adjudication or processing of any & all insurance claim(s) filed on my behalf & for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of Dallas Center for Dermatology & Aesthetics.

CONSENT TO TREAT: I hereby consent to treatment by my dermatologist to include examination and treatment, prescribing medication and skin preparations.

______________________________ ______________
PATIENT SIGNATURE (PARENT IF PATIENT IS MINOR CHILD) **DATE**

Dallas Center for Dermatology & Aesthetics
Lori Stetler, MD • Kristel Polder, MD • Jennifer Scheiderich, MS, PA-C • Charlene Wilson, CME

MEDICAL HISTORY

Patient Name:______________________ Occupation:______________________

Date of Visit:______________________ Referring Physician:______________________

Hobbies:______________________

Reason for Visit:______________________

Primary Care Physician:______________________ Address:______________________
(if different from Referring Physician above.

Telephone:______________________

Do you have any drug allergies?__________ If so, please list:______________________

Have you ever had any reactions to local anesthetics? Yes [ ] No [ ]
If yes, please explain:______________________
List all prescription and non-prescription medications you are currently taking:______________________

History of Skin Cancer? Yes or No: ☐ Melanoma ☐ Basal cell carcinoma ☐ Squamous cell carcinoma
Area of body__________ How treated?______________________

Do you have a family history of any of the following?
☐ melanoma ☐ skin cancer ☐ asthma ☐ eczema ☐ hay fever ☐ psoriasis
☐ hair loss ☐ diabetes ☐ adult acne ☐ genetic diseases
Other______________________

Please check appropriate box if you have a history of, or are currently under treatment for, the following conditions:
(if any are "yes". please explain on the lines below)

[ ]Yes [ ]No Heart Problems
[ ]Yes [ ]No High Blood Pressure
[ ]Yes [ ]No Pacemaker/Defibrillator
[ ]Yes [ ]No Stroke
[ ]Yes [ ]No Blood Clots
[ ]Yes [ ]No Bleeding Problems
[ ]Yes [ ]No Lung/Breathing Problems
[ ]Yes [ ]No H I V
[ ]Yes [ ]No Psychiatric Condition

[ ]Yes [ ]No Hepatitis
[ ]Yes [ ]No Diabetes
[ ]Yes [ ]No Kidney Problems
[ ]Yes [ ]No Arthritis
[ ]Yes [ ]No Epilepsy
[ ]Yes [ ]No Glaucoma
[ ]Yes [ ]No Rheumatic Fever
[ ]Yes [ ]No Artificial Joint/Valve
[ ]Yes [ ]No Mitral Valve Prolapse

[ ]Yes [ ]No Organ Transplant
[ ]Yes [ ]No X-ray Therapy
[ ]Yes [ ]No Ultraviolet Light Therapy (PUVA/UVB)
[ ]Yes [ ]No Skin Cancer
[ ]Yes [ ]No Cancer
[ ]Yes [ ]No Keloids
[ ]Yes [ ]No Currently Pregnant/Nursing
[ ]Yes [ ]No Require antibiotic prior to procedure

Other:______________________

[ ]Yes [ ]No Previous Surgery? If yes, explain type of surgery and give dates (no/yr) of each surgery:______________________

[ ]Yes [ ]No Alcohol Use? How much and how often?______________________

[ ]Yes [ ]No Tobacco Use? Types and amounts used per day?______________________

______________________ ______________
Signature of Patient (responsible party & relationship if patient is a minor) Date

______________________ ______________
Provider Signature Date

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Financial Policy

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate in discussing them with us.

Your Insurance

We make every effort to follow the guidelines required by your insurance company for both **in office** and **telemedicine** appointments. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

If your insurance coverage changes, it is your responsibility to notify our office at least **24 hours** before your next appointment. Failure to do so may result in rescheduling of your appointment. In addition, we may not be a provider with your new insurance. You will then be treated as a cash patient and given a superbill in order to file your own claim.

You may receive a separate bill from an off-site laboratory (Ameripath, Freeman-Cockerell, LabCorp etc) for any lab tests your physician may order. Please discuss any lab billing discrepancies with that laboratory.

With the exception of our Medicare patients, we DO NOT file secondary insurance.

Cancellations and Missed Appointments

All cosmetic appointments will require a credit card number on file upon scheduling. We kindly request that you give us a minimum of 24 hours notice if you are unable to keep your appointment. Failure to do so will result in a missed appointment fee. This fee is NOT covered by your insurance plan. The missed appointment fee schedule is as follows:

Medical - $85
Cosmetic – Minimum of $100 for each provider on the same day. Higher fees may be applied to procedures including, but not limited to, Thermage, Fraxel Repair, Fraxel Restore, CoolSculpting, Sculptra, Fotofacial, Botox, and fillers. In the case of prepaid packages, one session will be deducted from the package.

Returned check fee

There will be a $35 charge for all returned checks.
Collections: If your account is turned over to our collection agency, you will be responsible for the collection fee charged us by the agency in addition to your outstanding balance.

Your insurance card and driver's license will be required at check in.
I have read and understand the financial policy of the practice, and I agree to be bound by its terms.
I also understand and agree that such terms may be amended from time to time by the practice.

______________________________	______________________
Signature of Patient or Responsible party	Today's Date
______________________________	______________________
Printed Name of Patient	Date of Birth

In signing this HIPAA Patient Acknowledgement form , you acknowledge and authorize, that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, **Dallas Center for Dermatology and Aesthetics, PLLC** must have my consent, therefore, I authorize **Dallas Center for Dermatology and Aesthetics, PLLC**, to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (check all that apply)

☐All Procedures☐Test Results☐Appointments☐Other☐Surgeries☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than your referring doctor, family members and other specified person/persons)

Name:____________________Relationship:____________________

Name:____________________Relationship:____________________

Name:____________________Relationship:____________________

Name:____________________Relationship:____________________

Contact Information:

I authorize Dallas Center for Dermatology and Aesthetics to contact me at the following number with results or questions:

Home________________Cell________________Work________________

Email ____

May we leave a detailed message on your answering machine or voicemail?

Yes☐No☐ Failure to check one of these boxes may delay results

By Patient: (Print and sign)________________________________

Date:________________

Or Patient's Representative (Print name, sign and describe authority)

____

Date:________________