STEINER RANCH
Dermatology
4300 N. Quinlan Park Road, Suite 225
Austin, TX 78732
O: 512-266-0007 F: 512-266-0077

Dear New Patient,

Thank you for choosing Steiner Ranch Dermatology! Attached please find our New Patient Information Packet. Please fill it out as completely as possible.

You may return the Packet to us via fax (**266-0077**), or just bring it to your appointment. We ask that you arrive 15 minutes early if you choose the latter.

In addition to the Packet, we will need the following when you arrive for your appointment:

1. Driver's License
2. Insurance Card
3. Previous medical records as they pertain to your current problem or reason for your visit (biopsy reports and treatment plans are especially important)

We look forward to meeting you. If you have any questions, please feel free to call us at **266-0007**.

Sincerely,

Ted Lain, MD

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DEMOGRAPHIC INFORMATION:

Patient Name: ____ DOB: _____________

Address: ____Apt: _______________

City: _____________________________ State: _____________ Zip: _______________

Home Phone: ______________________ Cell Phone: ___________________________

Work Phone: ______________________ Messages: Home ☐ Cell ☐ Work ☐ None ☐

Email Address: ____

SS #: ________________ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employer: ____

Address: ____

Responsible Party: Self ☐ -- or --

Name: _______________________________________ Relationship: _______________

Address: ____

City: _______________________________ State: __________ Zip: ________________

Phone: _____________________________ Type: Home ☐ Work ☐ Cell ☐ Other ☐

SS #: ______________________________ DOB: ______________________________

Primary Pharmacy: ____

Location: __________________________ Phone: ____________________________

Emergency Contact: ___________________________ Relationship: _________________

Phone: _____________________________ Type: Home ☐ Work ☐ Cell ☐ Other ☐

INSURANCE INFORMATION:

Primary Insurance Company: ____

Insured Name: ______________________________ Insured DOB: _______________

Relationship: Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: __________________

Identification #: __________________________ Effective Date: _________________

Group Name: ___________________________ Group #: _____________________

Secondary Insurance Company: ____

Insured Name: ______________________________ Insured DOB: _______________

Relationship: Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: __________________

Identification #: __________________________ Effective Date: _________________

Group Name: ___________________________ Group #: _____________________

REFERRAL INFORMATION:

Referring Physician: ____

Location: _________________________________ Phone: ____________________

Reason: ____

____

____

Were you given a written insurance referral to our office? Yes ☐ No ☐

Were you given copies of your medical records/reports? Yes ☐ No ☐

When are you scheduled to return to the Referring Physician? _____________________

Primary Care Physician: ____

Location: _________________________________ Phone: ____________________

Brief Medical History (please be complete and accurate - this is very important information and allows us to provide you with the best care):

Typical Height: ______ Typical Weight: ______ Explain Recent Changes? ________________________________

Allergies: Please list all medications and herbals that you have allergies or adverse reactions to; and the type of reaction:

Medication:	Reaction:

Current Medications: Please list all medications, vitamins, and herbals you are currently taking; prescribed or over-the-counter:

Name of Medication:	Dosage:	How often taken:	Reason:

Previous Major Surgeries:

Type of Surgery:	Month/Year	Surgeon:	City, State:

Family History: Please list any illnesses that have occurred in your family:

Autoimmune disorder (Lupus, Rheumatoid Arthritis) Yes ☐ No ☐ Relation: ______________________________

Stroke Yes ☐ No ☐ Relation: ______________________________

Skin Cancer Yes ☐ No ☐ Relation: ______________________________

Melanoma Yes ☐ No ☐ Relation: ______________________________

Social History:

Do you currently smoke cigarettes? Yes ☐ No ☐ If so, how many per day? ___________

Do you drink alcoholic beverages? Yes ☐ No ☐ If so, how many per day? ___________

Review of Systems/Past Medical History:

Are you Hepatitis B or C positive? Yes ☐ No ☐ If so, which one, and have you been treated?_________

Are you HIV positive? Yes ☐ No ☐ Last CD4 count_______ Last viral load_________

Do you currently have, or have you ever had, problems with:

Constitutional

High, Prolonged Fever	Yes ☐	No ☐
Weight Loss	Yes ☐	No ☐
Excessive Fatigue	Yes ☐	No ☐
Night Sweats	Yes ☐	No ☐

Rheumatologic

Autoimmune disease	Yes ☐	No ☐	Explain__________________________

Cardiovascular

Atrial Fibrillation	Yes ☐	No ☐
Artificial heart valve	Yes ☐	No ☐
Congestive heart failure	Yes ☐	No ☐

Psychiatric/Neurologic

Anxiety	Yes ☐	No ☐	
Depression	Yes ☐	No ☐	
Migraines	Yes ☐	No ☐	
Seizures	Yes ☐	No ☐	Last episode______________________

Endocrine

Diabetes	Yes ☐	No ☐
Thyroid Disease	Yes ☐	No ☐
Irregular menstrual cycle	Yes ☐	No ☐

Hematologic / Lymphatic

Bleeding Tendencies	Yes ☐	No ☐
Clotting Tendencies	Yes ☐	No ☐
Persistent Swollen Glands	Yes ☐	No ☐

Allergic / Immunologic

Food Allergies	Yes ☐	No ☐	Explain: ___________________________
Inhalant (Nasal) Allergies	Yes ☐	No ☐	
Immunologic Disorders	Yes ☐	No ☐	

Skin Specific History

Do you have or have you had any of the following? (if yes, please check)

- ○ Acne
- ○ Actinic Keratosis
- ○ Atypical moles
- ○ Cold sores/herpes
- ○ Keloids or scarring problems
- ○ Psoriasis
- ○ Eczema
- ○ Contact Dermatitis (To what___________________________)
- ○ Rosacea
- ○ Other conditions

  Please list:

  ____

  ____

Patient Acknowledgement:

To the best of knowledge, the above information is true and correct.

____ __________

Patient Signature Date

If completed by someone else:

____ __________

Signature Date

____ ___________________________________

Printed Name Relationship

SIGNATURE PAGE

Release of Medical Information
I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Signature: ____*Date*:______/______/______

Financial Policy – All Patients, Including Medicare
Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. The patient is responsible for any/all charges not paid for by their insurance company. If you must cancel or reschedule an appointment, please do so at least 24 hours before the scheduled appointment time**. Steiner Ranch Dermatology** charges a fee of $50 to all patients who miss their appointment or do not notify the office of a cancellation 24 hours in advance. Please remember that our policies are created to allow for effective scheduling and to ensure all patients wishing to receive services may be accommodated. Please help us to better serve you.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to **Steiner Ranch Dermatology** when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to **Steiner Ranch Dermatology** for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. This authorization is valid until revoked in writing.

Signature: ____*Date*:______/______/______

Financial Policy – Medicare Patients Only
I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Signature: ____*Date*:______/______/______

Privacy Practices (HIPAA)
Receipt of Privacy Practices

- By signing below, I acknowledge that I have received a copy of **Steiner Ranch Dermatology's** Notice of Privacy Practices.

Contact Information

- By signing below, I authorize **Steiner Ranch Dermatology** to leave a message in reference to any items that assist the practice in carrying out healthcare operations. If you ***do not*** wish to be contacted at a specific location, please indicate below:

Home Phone:	**Do not contact me here**
Mobile Phone:	**Do not contact me here**
Work Phone:	**Do not contact me here**
Email:	**Do not contact me here**

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc):

Name: ____Relationship:_________________________

Name: ____Relationship:_________________________

Signature: ____*Date*:______/______/______