

**PATIENT INFORMATION**

**Please Print**

Today's Date \_\_\_/\_\_\_/\_\_\_

Patient Name \_\_\_\_\_  
**Last** **First** **M.I.**

Mailing Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Race \_\_\_\_\_ Preferred Language \_\_\_\_\_

Circle one- **Ethnicity**- Hispanic or Non-Hispanic Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_

E-mail address (**Please write legibly**): \_\_\_\_\_

**\*We are in the process of becoming a paperless office, so please provide an email address to receive billing statements, lab results, correspondence, promotional, etc.**

**PARENT OR GUARDIAN**

Name \_\_\_\_\_  
**Last** **First** **M.I.**

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_  
SS# \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_ E-mail \_\_\_\_\_

Other family members that are patients \_\_\_\_\_

In case of Emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**How did you hear about us?**

\_\_\_\_\_ **If referred by a Physician**, what is the physician's name \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy Phone Number \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

\_\_\_\_\_ YES \_\_\_\_\_ NO If yes, please provide their names and phone numbers below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): \_\_\_\_\_ Phone # (evening): \_\_\_\_\_

## PAYMENT POLICY

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. If you are on an insurance plan in which we participate, we will follow the contractual terms required, but it is the patient's responsibility to provide proper identification and, when necessary, the proper referral or other documents required by your insurance company. We accept Medicare assignment. Before insurance claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. I understand that my insurance carrier does not guarantee coverage; therefore I will be responsible for payment in full. If your carrier has not paid in sixty (60) days, we expect full payment from you. All services furnished by us are charged to the patient or, if a minor, his/her authorized guarantor, NOT the insurance carrier. In the event that your account must be turned over to collections, a collection fee will be added to your account. There is \$45 service fee for all returned checks. Your signature below signifies your understanding and willingness to comply with this policy. We accept payment in the form of cash, check or credit card. There is a \$25 no show/late cancellation fee. If you cancel without 24 hour notice, you will be charged the fee. Special circumstances will be subjected to the office manager's approval.

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. I also authorize payment of medical benefits to Dr George Wooming.

## AGREEMENT AS TO RESOLUTION OF CONCERNS

"Physician" shall be understood to mean George Wooming and Knox Dermatology.

I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the physician.

Should I, initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use an expert witness (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Dermatology. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Board of Dermatology.

I, agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Dermatology.

I, agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

George Wooming, MD  
Physician  
Effective from Date of Treatment

**Patient or Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

## HIPAA NOTIFICATION/ACKNOWLEDGEMENTS

Patient Name: \_\_\_\_\_

### Contact Information

The office of Dr. George Wooming would like to contact you for various reasons, including Personal Health Information (PHI) related to Appointment Reminders, Appointment Recalls and Notification of Test Results.

\_\_\_\_\_ Yes, you may leave PHI at the Primary Telephone Number and E-Mail address I provided.

\_\_\_\_\_ No, do not leave PHI.

### Notice of Privacy Practices Written Acknowledgement Form

I am a patient/parent/legal guardian of a patient of George Wooming, MDPA dba Knox Dermatology. I hereby acknowledge receipt of the Notice of Privacy Practices.

Do you give our office permission to discuss your private health information with other parties?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

If yes, please provide their names.

Spouse (List Name): \_\_\_\_\_

Parent (List Name): \_\_\_\_\_

Parent (List Name): \_\_\_\_\_

Other (List Name): \_\_\_\_\_

### Payment of Services and Notice Regarding Insurance

If you do not have active Medical Insurance, payment will be required in full at the time of your visit.

If you have active Medical Insurance under a Plan in which we do not participate, payment in full will be required at the time of your visit.

If we are filing insurance for your visit, we must have complete information, and any required referral information, at the time of your visit. If you cannot provide us with this information, we will not be able to file your claim and payment in full will be required at the time of your visit.

If we are able to determine that services provided will be charged against your Plan Deductible, such as surgical or office procedures, that amount may be due at the time of your visit, in addition to any Co-Pay or Co-Insurance.

### Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) has disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Facility with affiliation and remuneration: ADG Houston Pathology, PLLC

**Patient Name (Please Print):** \_\_\_\_\_

**Patient/Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ TODAY'S DATE \_\_\_/\_\_\_/\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

### **History and Intake Form**

**Past Medical History:** (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal	Lymphoma
Asthma	Disease	Pacemaker
Atrial fibrillation	Excessive Sweating	Prostate Cancer
BPH	GERD	Radiation Treatment
Bone Marrow	Hearing Loss	Seizures
Transplantation	Hepatitis	Stroke
Breast Cancer	High Blood Pressure	Valve Replacement
Colon Cancer	HIV/AIDS	None
COPD	High Cholesterol	
Coronary Artery	Hyperthyroidism	
Disease	Hypothyroidism	
Other _____		

**Past Surgical History:** (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None
Other _____	

NAME \_\_\_\_\_

**Skin Disease History:** (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin
Asthma	Hay Fever/Allergies	Cancer
Basal Cell Skin Cancer	Melanoma	None
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	
Other _____		

Do you wear Sunscreen?    Yes    No

If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?    Yes    No

Do you have a family history of Melanoma?    Yes    No

If yes, which relative(s)? \_\_\_\_\_

**Medications:** (Please enter all current medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** (Please enter all allergies)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had dental anesthesia (Novacaine)?**    \_\_\_\_\_Yes    \_\_\_\_\_No

**Any bad reaction?**    \_\_\_\_\_Yes    \_\_\_\_\_No

**Social History:** Please circle all that apply

**Currently smokes-daily**

**Currently smokes-not daily**

**Has never smoked**

**Has smoked in the past**

Other- \_\_\_\_\_

**Do you drink alcohol?**     Yes     No

If yes, \_\_\_\_\_ drinks per day

**Do you use IV drugs?**     Yes     No

If yes, what? \_\_\_\_\_ How often: \_\_\_\_\_

Have you had or have been exposed to HIV (AIDS)?     Yes     No

**(WOMEN)**    **Are you pregnant?**     Yes     No

Due date \_\_\_/\_\_\_/\_\_\_

NAME \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Hobbies? \_\_\_\_\_

**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-keloid or hypertrophic		
Immunosuppression		
Changing mole		
Rash		
Abdominal pain		
Anxiety		
Bloody stool		
Bloody urine		
Blurry vision		
Chest pain		
Cough		
Depression		
Fever/Chills		
Headaches		
Hay fever		
Joint aches		
Muscle weakness		
Neck Stiffness		
Night sweats		
Seizures		
Shortness of breath		
Sore throat		
Thyroid problems		
Unintentional Weight Loss		
Wheezing		

Pharmacy Name: \_\_\_\_\_ Pharmacy #: \_\_\_\_\_

Other Symptoms: \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ TODAY'S DATE \_\_\_/\_\_\_/\_\_\_

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Other Symptoms: \_\_\_\_\_