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_____
City *State* *Zip*
Home Phone_____Work Phone_____ 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 select all that apply)

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

Other _____

Past Surgical History: (please select all that apply)

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

Other _____

NAME_____

_ Skin Disease History: (please select 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 select all that apply

☐**Currently smokes-daily**	☐ **Has never smoked**
☐**Currently smokes-not daily**	☐ **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 select 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: _____