Anh V. Nguyen, Dermatologist
Adam V. Nguyen, Dermatologist

ADVANCED DERM-PLASTIC, P.A.
455 School Street #49
Tomball, TX 77375
281-351-9823

Anson V. Nguyen, Plastic Surgeon
Info@advanceddermtx.com

Date: _____

LAST NAME: _____ FIRST NAME: _____ MI_____ DATE OF BIRTH: _____/_____/_____

GENDER: ❑ MALE ❑ FEMALE SOCIAL SECURITY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME: _____ CELL: _____ PREFERRED CONTACT: ❑ EMAIL ❑ CELL

EMAIL: _____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ OTHER: _____

EMERGENCY CONTACT: FULL NAME: _____ PHONE: _____

PREFERRED PHARMACY: _____NUMBER: _____

ADDRESS: _____ ZIP: _____

NAME OF PARENT OR RESPONSIBLE PERSON: ❑ SAME AS PATIENT ❑ PARENT ❑ OTHER _____

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY HOLDER INFORMATION: ❑ SAME AS PATIENT ❑ PARENT ❑ OTHER _____

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

PHONE: _____ RELATIONSHIP TO PATIENT: ❑ PARENT ❑ SPOUSE ❑ OTHER_____

REFERRING PROVIDER (If you were referred): _____

RELEASE OF INFORMATION

I, _____, HEREBY AUTHORIZE THE OFFICE OF ADVANCED DERM-PLASTIC, P.A.
PRINT NAME
TO RELEASE ALL MEDICAL INFORMATION TO:

1. **NAME:** _____ **DATE OF BIRTH:** _____/_____/_____ **RELATIONSHIP:** _____
2. **NAME:** _____ **DATE OF BIRTH:** _____/_____/_____ **RELATIONSHIP:** _____
3. **NAME:** _____ **DATE OF BIRTH:** _____/_____/_____ **RELATIONSHIP:** _____

SIGNATURE: _____ **DATE:** _____

PATIENT NAME: _____

Your main reason for today's visit: _____

CURRENT MEDICATIONS: _____

_____

_____

MEDICATION ALLERGIES: _____

Allergies to: Topical Antibiotics, Adhesives, Lidocaine, Epinephrine

Do you: Smoke: YES/NO (if yes: packs/day: _____ x _____ years) # of Children _____
Drink? YES/NO (if yes, ___ glass/day) **WOMEN – Are you pregnant** ☐ **YES/NO** ☐

PLEASE CIRCLE THE FOLLOWING SYMPTOMS THAT YOU MAY HAVE:

*FEVER ☐	CHILLS ☐	NIGHT SWEATS ☐	WEIGHT CHANGES ☐
*BLURRY VISION ☐	DOUBLE VISION ☐	LIGHT SENSITIVITY ☐	SHORTNESS OF BREATH ☐
*NOSE BLEEDS ☐	HEARING LOSS ☐	RINGING IN EARS ☐	DIARRHEA ☐
*CHEST PAIN ☐	MURMURS ☐	PALPITATIONS ☐	INCONTINENCE ☐
*COUGH ☐	SPUTUM ☐	WHEEZING ☐	RASHES ☐
*NAUSEA ☐	VOMITING ☐	ABDOMINAL PAIN ☐	HEADACHE ☐
	BLOODY/BLACK STOOL ☐	APPETITE CHANGES ☐	FAINTING ☐
*PAINFUL URINATION ☐	FREQUENT URINATION ☐	BLOODY URINE ☐	
*JOINT PAIN ☐	MUSCLE PAIN ☐	WEAKNESS ☐	
*CHANGES IN MOLES ☐	NEW MOLES ☐	ITCHING ☐	
*LOSS OF BALANCE ☐	DIZZINESS ☐	CONFUSION ☐	
	NUMBNESS ☐	SEIZURES ☐	
*ABNORMAL IDEATION ☐	ANXIETY ☐	DEPRESSION ☐	
*ANEMIA ☐	BLEEDING PROBLEMS ☐	LYMPHEDEMA ☐	

YOUR CURRENT OR PAST MEDICAL CONDITIONS/SURGERIES (please give details):

AIDS/HIV _____ HEAD/EYES/EARS/NOSE/THROAT/MOUTH_____
HEART (AS A VALVE REPLACEMENT) _____ NEUROLOGIC/PSYCHOLOGICAL DISORDERS _____
DIGESTIVE SYSTEM_____ URINARY SYSTEM _____
SKIN DISORDERS _____ REPRODUCTIVE SYSTEM _____
LUNGS _____ THYROID/DIABETES/HORMONAL PROBLEMS_____
RHEUMATOLOGY _____ DYSPLASTIC MOLES _____
CARDIOVASCULAR DISORDERS _____
ORTHOPEDIC DISORDERS (SUCH AS KNEE/HIP REPLACEMENT) _____
PROSTHESIS/IMPLANTS (PACEMAKER OR PACEMAKER/DEFIBRILLATOR) _____
CANCERS (SUCH AS SKIN CANCER, OVARIAN, THYROID, LUNG)_____
*OTHER: _____

FAMILY HISTORY	MOTHER	FATHER	SIBLINGS	CHILDREN
Asthma	_____	_____	_____	_____
Cancers	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Eczema	_____	_____	_____	_____
Hay Fever/Allergies	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Inflammatory Bowel (CROHN'S DISEASE/ULCERATIVE COLITIS)	_____	_____	_____	_____
Lung Disease	_____	_____	_____	_____
Lupus	_____	_____	_____	_____
Malignant Melanoma	_____	_____	_____	_____
Psoriasis	_____	_____	_____	_____

Other: _____

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SECTION I

OFFICE / FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE AND TREATMENT. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE YOU TO READ AND SIGN PRIOR TO YOUR TREATMENT.

PAYMENT IS DUE AT TIME OF SERVICE!

WE ACCEPT CASH, CHECKS, VISA, MC, AMERICAN EXP, DISCOVER, AND CARE CREDIT.

Regarding Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If you have insurance coverage with one of the plans we participate in, we will bill your insurance company in accordance with the guidelines of our contract. **However, we require that ALL CO-PAYS OR DEDUCTIBLES be paid at the time of service.** You understand that your **COPAY** is for an **OFFICE VISIT** and it may **NOT** apply to certain office procedures (such as excision, biopsy, cryotherapy, etc.) as dictated by your insurance policies. You are responsible for any amount not covered and /or applied to your deductible. No charges or payments are guaranteed until your insurance company processes your claims. Any amount remaining may be patient responsibility after your claim has been processed, even after you have paid in the office.

If we do not participate in your insurance plan, you are responsible for payment at the time services are rendered. You are responsible for obtaining reimbursement from your insurance.

IF YOU HAVE MEDICAID, WE CANNOT SEE YOU

It is our office policy that since we are not a contracted provider with Medicaid we cannot see you. You will need to find a provider in the Medicaid network. Medicaid will not pay for any services since we are not a contracted provider. Medicaid may not cover any prescriptions that you receive from us.

You will be required to show a copy of your insurance card and photo identification at the time of service for each visit. **If you do not have your insurance information you will be required to pay for the services rendered to you that day**. We do not accept third party insurance or auto accident claims.

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Regarding Referrals: PRIOR TO THE VISIT, IT IS THE RESPONSIBILITY OF THE PATIENT TO OBTAIN A REFERRAL FROM THEIR PCP, if required by the patient's insurance plan. We will **NOT** call the patient's PCP to solicit referrals!

Minor Patients: The parent (guardian) who presents the child for medical treatment is the responsible party. If payment for services is to be by someone else, the parent with the child should pay and have the other party reimburse them. Any legal agreement between the parents has nothing to do with this practice.

Other Fees: Your check will be accepted with proper identification and is subject to approval by Telecheck. There will be a $25 fee for each returned check.

As of 01/01/2018: **CANCELLATIONS OR MISSED APPOINTMENTS**. If you do not call and cancel your appointment at least 24 hours before, or if you No-Show, we will assess you a $25 missed appointment fee for office visits, $75 No-Show fee for Cosmetic appointments, and $100 No-Show fee for surgery visits.

As Of 10/01/2018: DELINQUENT ACCOUNTS. Accounts will be considered delinquent after 90 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with the collection agency will be subject to all reasonable collection and/or court costs. If you have any questions or concerns about your statements or accounts, please call the office at 281-351-9823.

Thank you for understanding our Office / Financial Policy. Please let us know if you have questions or concerns.

SECTION II

AUTHORIZATION AND ACKNOWLEDGEMENT

I have read, understand and agree to the above Financial Policy.

I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Name: (Please print) _____ Date: _____

Patient /Guarantor Signature: _____

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PHOTO/SOCIAL MEDIA CONSENT AND RELEASE FORM

Patient Name (Print): _____

I consent for photographs and/or video images to be taken of me by Advanced Derm-Plastic, P.A. or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

_____ YES _____ NO For educational purposes (medical teaching or training),

_____ YES _____ NO For marketing and advertising purposes (website, print, digital, or social media),

_____ YES _____ NO At my request, my photographs and/or video images will be used as part of my medical record.

I hereby release Advanced Derm-Plastic, P.A., its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to Advanced Derm-Plastic, P.A. or by completion of a new form.

Patient Signature: _____ Date: _____