

Park Cities Dermatology Center

8226 Douglas Ave, Suite 540

Dallas, TX 75225

214-692-7447

Please note that the parking in our building is VALET ONLY.

Patient Name	_____	Date	_____
	First MI Last		
Home Address	_____	City	State Zip
	Street/Apt		
Home Phone	_____	Work Phone	_____ Cell Phone _____
Employer	_____	Occupation	_____
Work Address	_____	City	State Zip
	Street/Suite		
Date of Birth	_____	Age	_____ Social Security Number _____
Drivers Lic #	_____	State	_____ Gender _____ Marital Status _____
Emergency Contact	_____	Relationship	_____
Home Phone	_____	Work Phone	_____ Cell _____
Referred By	_____		

PERSON RESPONSIBLE FOR PAYMENT (if different from above information)			
Name	_____	Relationship	_____
Address	_____	City	State Zip
	Street/Apt#		
Home Phone	_____	Work Phone	_____ Cell _____
Social Security Number	_____	Date of Birth	_____

INSURANCE INFORMATION **Present Your License, Medicare and/or Insurance Cards**			
Primary Insurance _____			
Policy Holder	_____	Relationship	_____ DOB _____
Insurance Effective Date	_____		
Secondary Insurance _____			
Policy Holder	_____	Relationship	_____ DOB _____
Insurance Effective Date	_____		

MEDICAL HISTORY

Patient Name: _____

Please list any drug allergies _____

Other allergies _____

Please list all medications you are currently taking (include all over the counter medications): _____

Are you under the care of a Physician? Yes No

Name of Personal Physician _____ Physician's Phone # _____

Please list any significant current or past medical illness with dates: _____

Please list any major surgeries with dates: _____

Do you smoke? Yes No

DO YOU TAKE ASPIRIN? YES NO

Do you drink alcohol? None Occasionally Moderately

Have you ever had a bad surgical result? Yes No Explain _____

HAVE YOU EVER USED A TANNING BED? YES NO YES CURRENTLY

If female, are you pregnant or planning a pregnancy? Yes No

Have you ever had or been treated for: Please circle YES where applicable.

AIDS	Yes	Frequent infections (skin)	Yes	Neurological Disorder	Yes	FAMILY HISTORY	
Allergy to local anesthetic	Yes	Gallbladder Disease	Yes	Radiation	Yes		
Arthritis	Yes	Glaucoma	Yes	Rheumatic Fever	Yes	Asthma	Yes
Artificial Joint	Yes	Have you ever taken Accutane	Yes	Seizures	Yes	Eczema	Yes
Auto-Immune Disease	Yes	Hayfever	Yes	Skin Cancer	Yes	Melanoma	Yes
Blood Disease	Yes	Heart Surgery	Yes	Stroke	Yes	Psoriasis	Yes
Bone Disease	Yes	Heart Disease	Yes	Thrombophlebitis	Yes	Skin Cancer	Yes
Cancer	Yes	Heart Attack	Yes	Thyroid	Yes		
Cardiac Pacemaker	Yes	Hepatitis	Yes	Urinary/Bladder problems	Yes		
Cataract Surgery	Yes	Herpes	Yes	Venereal Disease	Yes		
Chemotherapy	Yes	High Blood Pressure	Yes	Yeast Infections	Yes		
Colitis	Yes	HIV	Yes	Raynaud's (cold intolerance)	Yes		
Diabetes	Yes	Intestinal Disease	Yes				
Difficulty with healing	Yes	Keloids or scarring	Yes				
Duodenal or Peptic Ulcer	Yes	Kidney Disease	Yes				
Eczema	Yes	Liver Disease	Yes				
Emotional/Psychiatric problems	Yes	Lung Disease (Tuberculosis)	Yes				
Excessive bleeding when cut	Yes	Lymph Gland Disorder	Yes				
Eye Disease	Yes	Mitral Valve Prolapse	Yes				

I have completed this form fully and completely, and certify that I am the patient or duly authorized to furnish the information requested. I understand that even though I have some insurance coverage, I am responsible for payment of services, at the time services are rendered. I authorize release of information to my insurance company.

Signature

Date

Max F. Adler, M.D., Sandra G. Witten, PA-C, Denis L. Beaudoin, M.D.
8226 Douglas Avenue, Suite 540 Dallas, TX 75225 214-692-7447

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HIPPA
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of Park Cities
Dermatology's Notice of Privacy Practices.

Signature of Patient

Date

If a Personal Representative's signature appears above, please describe Personal Representative's relationship to patient.

Thank you.

PARK CITIES DERMATOLOGY
PATIENT AUTHORIZATION USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Park Cities Dermatology to use and/or disclose certain protected health information (PHI) about me to:

1. _____ Patient Name
 2. _____ Spouse Name
 3. _____ Parent or Guardian Name
-

This authorization permits Park Cities Dermatology to use and/or disclose the following individually identifiable health information about me) specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): **ALL MY MEDICAL INFORMATION BY PHONE OR FAX.**

The information will be used or disclosed for the following purpose: **“At the request of the individual.”** If requested by the patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on **NO EXPIRATION DATE.**

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Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name Date

Print Name of Patient or Legal Guardian