Steven Richardson, MD, FAAD
Faith Stewart, MD, FAAD
American College of Mohs Surgery
Fellowship Trained / Board Certified

PATIENT REGISTRATION

Legal Name: ____
Last | First | Middle Initial | Birthdate

Billing Address: ____
Street | City/State | Zip Code

Home Phone #: ____________ Cell Phone #: ____________ Work Phone #: ____________

How would you like to receive appointment reminders? ☐ Voice ☐ Text ☐ No Reminders

Which phone number can we leave appointment reminders? ☐ Home ☐ Cell ☐ Work

Email Address: ____

Do we have permission to leave a detailed message regarding your health information at your phone numbers listed above?

Yes to: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ No Detailed Message

May we discuss your medical care/condition with any member of your household?

If yes, who: ______________________ Relation: ______________________

Social Security Number: ______________________ Employer: ______________________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Primary Care Physician: ____
Last | First | Phone

Referring Physician: ____
Last | First | Phone

Emergency Contact: ____
Name | Relationship | Phone

INSURANCE INFORMATION

Primary Subscriber Legal Name: ____
Last | First | Birthdate

Primary Subscriber Billing Address: ____
Street | City/State | Zip Code

Secondary Ins Subscriber Legal Name: ____
Last | First | Birthdate

Secondary Ins Subscriber Billing Address: ____
Street | City/State | Zip Code

PARENT OR GUARDIAN INFORMATION (if applicable)

Name: ____________ Relationship to Patient: ____________ Phone: ____________

SSN: ____________ Birthdate: ____________ Is Parent/Guardian a patient at MVSD? ____________

Address: ____
Street | City/State | Zip Code

PATIENT ACKNOWLEDGEMENT

The above information is true to the best of my knowledge.

____ ____________________

Signature of Patient (or guardian if a minor) **Date**

Mira Vista
SURGICAL DERMATOLOGY
7000 Bryant Irvin Rd, Suite 100, Fort Worth, TX 76132
(o) 817-882-6338 | (f) 817-759-9808

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Intake and History Form

Name: ____ Date: ________/________/________
(Last) (First) (Middle)

Preferred Pharmacy

Name: ______________________________________ City or Zip Code: ______________________

Phone Number: ________________________________ **May we import medicine list from pharmacy?** ☐ YES ☐ NO

Medical History

Select or include any of the following medical conditions you have a history of:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ OTHER MEDICAL HISTORY:

____
____
____

When did you receive the following vaccinations: Pneumonia________ ; Influenza________; Not able to receive vaccination for the following reason: ___Allergic / ___Medical Reason / ___Other (please specify) ______________________________

Have you been seen by your primary care physician recently? ☐ YES ☐ NO When was your last visit? ____________________

Have you been hospitalized within the last 30 days? ☐ YES ☐ NO

If recently hospitalized, have you seen another provider in follow-up to your hospital stay? ☐ YES ☐ NO
Name of provider seen: ____

Surgical History

Have you had any of the following surgeries:

- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA (angioplasty)
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
  Year: ______________
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
  Year: ______________

Name: ______________________________ Date: ______/______/______

- ☐ Kidney: Kidney Transplant (Year: __________)
- ☐ Kidney: Nephrectomy (Year: __________)
- ☐ Liver: Liver Transplant (Year: __________)
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Skin: Basal Cell Carcinoma Treatment
- ☐ Skin: Melanoma Treatment
- ☐ Skin: Squamous Cell Carcinoma Treatment
- ☐ Spleen (Splenectomy)
- ☐ NONE
- ☐ OTHER

____

____

____

Skin Disease History

Have you had any of the following?

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

____

____

Do you wear sunscreen routinely?

○ 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?

Medications (INCLUDE DOSAGE AND FREQUENCY)

List all current medications WITH dosage and frequency OR provide list:

Name: ____ Date: ______/______/______

Allergies

List all allergies and reactions if known:

____

____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking (mm/dd/yyyy) : ________________________

Quit Smoking (mm/dd/yyyy): __________________________

Number of Packs Per Day: _________

Total Years Smoking: _____________

Alcohol Intake (please choose one):

- ☐ None
- ☐ Less than 1 per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Occupation and Workplace:

____

Family History

Please include any pertinent family history (only first-degree relatives):

____

____

Do you have a healthcare proxy? ☐ YES ☐ NO If yes, who has been designated? ______________________________

Alerts - **Please check yes or no for the following:**

Symptom	Yes	No
Allergy to adhesive		
Allergy to lidocaine		
Allergy to antibiotic ointments		
Artificial heart valve		
Artificial joints within the past two years		
Blood thinners		
Defibrillator		
History of MRSA		
Pacemaker		
Rapid heartbeat with epinephrine		
Pregnancy or planning a pregnancy		
HIV/Aids		
Hepatitis B or C		

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BILLING/INSURANCE AGREEMENT AND FINANCIAL POLICY

Patient Name: ____ **Birthdate:** ___________________________

OFFICE POLICIES ALL APPOINTMENTS: We ask for 2 days' notice for all reschedules and cancellations of appointments. This courtesy allows our office to schedule another patient in your place. If an emergency arises, please give as much notice as possible. Failure to show up to a scheduled appointment without a cancellation phone call will be subjected to a fee.

Medical No Show Fee: $50 office visit or $150 surgery appointments.

When a patient is more than 10 minutes late, we reserve the right to shorten or reschedule the appointment, if needed, to not inconvenience other patients.

There is a $35 **returned check fee** for any checks returned to us by the bank.

INSURANCE COVERAGE COMMERCIAL: I will be responsible for paying my copay at the time of my visit as required by my insurance. I will pay my annual deductible, coinsurance and charges for any service/procedure deemed not medically necessary, pre-existing or cosmetic by my insurance.

INSURANCE CARD AND IDENTIFICATION: I will provide my correct address, phone number, photo ID and a copy of my insurance card at the time of each appointment. This will enable Mira Vista Surgical Dermatology to accurately bill charges on my behalf and protect me against identity theft. Without the presence of my insurance card, I will need to pay in full at the time of service. I will be provided with a receipt which I may submit to my insurance company myself.

UNINSURED: I understand that payment in full is due at the time of service and agree to pay my balance in full at the time of service including any services due for sending pathology specimens out.

REFERRALS: If my insurance company requires a referral to see a specialist, I understand that I am responsible for obtaining the referral prior to my visit and renewing my referral when needed for subsequent visits. If I fail to do so, I agree to pay the entire unpaid balance remaining from by insurance.

OTHER: I understand that my private insurance and/or commercial plan in which my physician is not a covered provider may be covered at a lower rate or not at all. I agree to take full financial responsibility for the entire unpaid balance left after payment from my insurance.

NON-CONTRACTED INSURANCE: Mira Vista Surgical Dermatology is a private dermatology practice that participates with most major insurance carriers and Medicare. Due to the increasing number of insurance plans, our office is unable to guarantee coverage by any individual plan. Your insurance policy is a contract between you and your insurance carrier. It is your responsibility to verify that Mira Vista Surgical Dermatology is a member of your PPO or HMO network (including Medicare) before coming to our office for treatment. You can verify this information directly by calling the toll free customer service number located on the back of your insurance card. We do not accept the following insurance plans: Medicaid, Chip, Star Plus, Molina, TexanPlus, Worker's Comp or Superior. This list is not all inclusive. It is my responsibility to check with my insurance carrier/policy regarding coverage.

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BILLING/INSURANCE AGREEMENT AND FINANCIAL POLICY (CONT.)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Please sign below to acknowledge understanding of all policies listed above and on prior page.

____ _________________________________

Signature of patient (or guardian if a minor) **Date**

MEDICARE PATIENTS ONLY – Signature on File: I request payment of authorized Medicare benefits made either to me or on my behalf to Richardson Dermatology, PLLC dba Mira Vista Surgical Dermatology for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me be released to the Health Care Financial Administration and its agents; any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

____ _________________________________

Signature of patient (or guardian if a minor) **Date**

LABORATORY & PATHOLOGY BILLING:
I will receive prompt notification of any biopsy results that are abnormal or require immediate attention, otherwise I will be notified as soon as possible. If I have any concerns after my biopsy has been done and I have not been contacted, I may contact the office immediately. I have been informed that it takes 7 to 10 business days before I will receive my results unless a rush was placed on the reading. Biopsies collected will be sent to an outside laboratory (ProPath) for results and I will receive a separate bill from them for this service. This is billed separately and is my responsibility. Insurance plans have many benefit levels and only I can be sure that my insurance company processed the claim according to my specific plan provisions.

____ _________________________________

Signature of patient (or guardian if a minor) **Date**

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Mira Vista Surgical Dermatology

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment & improvement activities

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name: ____ Date of Birth:_______________________

Signature: ____ Date: ______________________________

Relationship to Patient: _____________________________________

Dependent family members also covered by this acknowledgement:

____

I give authority for Mira Vista Surgical Dermatology to disclose my health information to the following people:

____

____

____

MIRA VISTA SURGICAL DERMATOLOGY
7000 Bryant Irvin Road, Suite 100
Fort Worth, TX 76132
Phone: (817) 882-6338
Fax: (817) 759-9808