Center for Dermatology
&
Cosmetic Laser Surgery

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5044 Tennyson Parkway Suite B
Plano, TX 75024
Phone 972-985-9003
Fax 972-985-1176

Welcome to The Center for Dermatology and Cosmetic Laser Surgery!

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at 972-985-1176 prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust in your physician. We want to provide you with the most up to date information and treatment options regarding your skin care health. We do appreciate and value the trust you have placed in us.

The Center for Dermatology specializes in the diagnosis and treatment of skin, hair and nail disease, as well as cosmetic laser treatments and surgeries. We provide our patients and their families with full-service, comprehensive dermatological care. We desire to assist you in receiving the best of what today's medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We assure you, we will do our best to give you total satisfaction.

We value highly the relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback matters because it helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Bryan A. Selkin, MD

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay** or **Deductible** is collected at the time of visit
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Driver's License or State Issued Photo ID**

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Please print forms in blue or black ink only

Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.

Release of Medical Information

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 electronically to your pharmacy.

Signature: _____Date:_____/_____/_____

Financial Policy

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level than what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. **In an effort to ensure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.**

We accept payment in the form of cash, check, Visa and MasterCard. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. For appointments which are missed or cancelled with less than 24 hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Nicole Reed Medical Center for Dermatology when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Nicole Reed Medical Center for Dermatology for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____Date:_____/_____/_____

Privacy Practices (HIPAA)

I have been given the opportunity to review, understand and consent to this practice's Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

Signature: _____Date:_____/_____/_____

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How did you find us?
- Family/Friend - Name:_____
- Insurance Provider List
- Internet Search
- Newspaper Ad
- Physician - Name:_____
- Yellow Pages
- Other_____

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____

Previous Name: _____
(Maiden name, former married name, etc.)

Home Address: _____
(No PO boxes)

City: _____

State: _____ Zip Code: _____

Number for appointment reminders and test results: (_____)_____
May we leave a message at this number? ❑ Yes ❑ No
Secondary Phone: (____)_____Work Phone: (_____)_____

Email Address: _____

Date of Birth: _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number: _____

Primary Care Physician: _____
(First and Last Name)
Phone number: (_____)_____ City: _____

Did a doctor's office send you to us for a specific problem? ❑ Yes ❑ No

If YES, name of referring provider: _____

Race: ❑ African American ❑ Asian ❑ Hispanic ❑ Native American ❑ White ❑ Pacific Islander ❑ Other ❑ Decline to report

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Declined to report

Responsible Party, if different from patient information above:
(statements will be addressed to the responsible party)

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Date of Birth: _____ ❑ Male ❑ Female

Phone: (_____)_____ Email: _____

Relationship to patient: _____

Adult Emergency Contact:

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: (_____)_____ Alt. Phone: (_____)_____

Relationship to patient: _____

INSURANCE INFORMATION: If the patient is not the primary policy holder, the Responsible Party section above must be completed.

❑ Self Pay *(no insurance)* ❑ Patient IS the policy holder ❑ Patient IS NOT the policy holder

Primary Insurance Co.: _____ Policy Number _____

Secondary Insurance Co.: _____ Policy Number _____

Does your insurance plan require you to have a referral to see a specialist? ❑ No ❑ Yes ❑ I don't know
NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

SUBSCRIBER INFORMATION (REQUIRED if patient is not the primary insurance policy holder):

Name: _____

Social Security #:_____ Date of Birth:_____

PHARMACY INFORMATION:

Name: _____

Location (City and Intersection):_____

_____

Phone: (_____)_____

By signing below, I authorize The Center for Dermatology and Cosmetic Laser Surgery to administer care as is deemed necessary.

Patient or Responsible Party **Signature of Agreement**_____ Date _____

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Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave **DETAILED** information related to the following, on your voicemail:

❑ Test results, labs, medical issues ❑ Billing questions ❑ Scheduling issues

Primary (_____) _____ Secondary (_____) _____

It is our practice policy to confirm all scheduled visits with a phone call or email. This will be done for all patients. Please notify the receptionist if there is an urgent reason not to confirm appointments.

Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information related to the following to your email:

❑ Appointments ❑ Billing ❑ Test results, diagnosis, and procedures

Email address: _____

Would you like our monthly specials and updates about new technology sent to your email? ❑Yes ❑No

Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent.

I authorize this facility to speak to the following family members or my personal representative regarding

❑ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.

❑ Only the following types of information: _____

❑ Do not disclose any information on file other than to patient on record.

The above medical information shall only be released to the following person(s):

1._____Relationship: _____ Phone number: _____

2._____Relationship: _____ Phone number: _____

3._____Relationship: _____ Phone number: _____

Authorization to Send a Text Message

Please provide a number **ONLY IF** you approve us to leave **DETAILED** information related to appointments, billing, test results, diagnosis, and procedures in a text message. (_____)_____

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time. I have been given the opportunity to review, understand and consent to this practice's Notice of Privacy Practices as written.

Name **(PRINTED)** _____

Signature_____

Date_____

Name (First, Middle, last): _____

Today's date: _____

Date of Birth: ___/___/_____ Male Female

Reason for today's visit: _____

_____

Center for Dermatology
and Cosmetic Laser Surgery

ALLERGIES/INTOLERANCES

Are you allergic to any prescription or over the counter medications: Yes No

Medication	Reaction

Are you allergic to:	Yes	No
Latex		
Bandages/Tape		
Neosporin/Polysporin		

Other medications: _____

Have you ever had a reaction to numbing medications such as what a dentist uses (lidocaine) or general anesthetics? Yes No

If yes, please give details on agent and reaction: _____

_____

Do you get dizzy or faint easily when undergoing a medical procedure or having blood drawn? Yes No

CURRENT MEDICATIONS

Current medications and reason for taking (please list prescription, over the counter, supplements, vitamins and herbal):

Medication	Reason	Medication	Reason

Other medications: _____

PERSONAL MEDICAL HISTORY

Medical Condition	Yes	No
Artificial Heart Valve		
Artificial/Prosthetic Joint		
Immunosuppressive medications such as steroids (prednisone)		
Kidney disease If yes, please specify		
Diabetes If yes, type I or II		

Medical Condition	Yes	No
HIV/AIDS		
Hepatitis If yes, A B C D		
Organ transplant If yes, organ/year		
Pacemaker		
Defibrillator		
Asthma		
Allergic Rhinitis		
Anemia		

Center for Dermatology
and Cosmetic Laser Surgery

Medical History	Yes	No
Arthritis		
Blood clots		
Thyroid disease		
Liver disease If yes, please specify		
Dialysis		
Bleeding abnormality If yes, please specify		
Clotting disorder If yes, please specify		
Multiple Sclerosis		
Do you take ABX prior to procedures?		
Stroke		
Hypertension		
Heart attack		
Irregular Heartbeat/Atrial Fib		

Medical History	Yes	No
Heart Murmur		
Crohn's disease		
Ulcerative colitis		
Epilepsy (seizures)		
Depression		
Tattoo		
Tuberculosis		
Cataracts		
Autoimmune disease If yes, specify		
Hives		
Cancer (other than skin) If yes, specify		
Lupus		
Sjogrens		

Other medical problems not listed: _____

_____

Other Questions:	Yes	No
Have you ever had basal or squamous cell carcinoma skin cancer? If yes, specify which one, the location(s) and year(s)?		
Do you develop keloids (large thick scars) after injuries or surgeries?		

Other Questions:	Yes	No
Have you ever had malignant melanoma? If yes, specify location and year.		
Have you had blistering sunburns as a child?		

For females only:	Yes	No
Pregnant If yes, how many weeks		
Breastfeeding		
Hysterectomy		
History of migraine headaches		

For females only:
Are periods regular or irregular (if applicable)
Birth control methods currently being used, if any

PAST SURGICAL HISTORY/HOSPITALIZATIONS (MAJOR ONES ONLY)	Date

Center for Dermatology
and Cosmetic Laser Surgery

FAMILY HISTORY

Specify which blood relative. (mother, father, sister, brother, aunt, child, grandparent)

Family History:	Yes	No	Relationship
Basal Cell Carcinoma			
Squamous Cell Carcinoma			
Melanoma			
Multiple sclerosis			

Family History:	Yes	No	Relationship
Thyroid disease			
Hair loss			
Psoriasis			
Eczema			
Seasonal Allergies			

SOCIAL HISTORY

What is your occupation? _____

Who is your employer? _____

Marital Status: Single Married Divorced Separated

	Current Frequency	Former Frequency	Never
Tobacco use			
Alcohol			

Please list hobbies: _____

_____

REVIEW OF SYSTEMS

Constitutional
Weight change
Loss of appetite
Night sweats

Neurology
Headache
Seizures
Dizziness

Endocrine
Excessive thirst
Heat intolerance
Cold intolerance

Gastroenterology
Diarrhea
Blood in Stool
Abdominal pain

Musculoskeletal
Joint stiffness
Joint swelling
Muscle aches

Ear, Nose and Throat
Nose Bleeds
Sore Throat
Difficulty swallowing

Cardiology
Chest pains
Palpitations
Ear fullness

Allergy
Runny nose
Sneezing

Psychology
Depression
Mood swings
Suicidal ideation

Hematology
Easy bruising
Swollen glands
Fatigues

Respiratory
Shortness of Breath
Cough Wheezing

Urology
Blood in urine
Frequent urination

Opthalmology
Eye irritation
Blurry vision

_____

Other Comments: _____

_____

_____

Signature: _____ Date: _____

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and Cosmetic Laser Surgery

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and Cosmetic Laser Surgery

Cosmetic Questionnaire

Last Name_____ First Name_____
Date of Birth_____ Email_____

As our patient, we want to help you discover your cosmetic interests and goals, and inform you of ways to achieve them. Our team can devise a holistic approach to bring you healthier skin, a more youthful appearance, and treatment for any cosmetic concerns that you have.

Do you have any cosmetic concerns that if treated, would make you feel better?
_____

Our Cosmetic Coordinator Ashlae will contact you to discuss all options and any concerns you may have. Please provide the best contact number to be reached at.
_____

Thank you

Our SelkinMD product skin care line is available for purchase online at www.selkinmd.com