1584 E Common St. New Braunfels TX, 78130 - P:(830) 609-4700 F: (830) 608-0470

PATIENT REGISTRATION

PLEASE PRINT

NAME: _____

ADDRESS:_____

CITY:_____ STATE: _____ ZIP: _____

HEIGHT:_____ WEIGHT:_____ MARITAL STATUS:_____

SEX:_____ DATE OF BIRTH:_____ SOCIAL SECURITY #_____

PARENT: _____ PHONE (____) _____
IF PATIENT IS A MINOR (UNDER 18)

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

EMAIL ADDRESS:_____

HOME (_____)_____ WORK (_____)_____ CELL(____)_____

WHEN CONTACTING ME (please check all that apply):

__ Leave a message with a call back number only
__ Do not leave a message
__ Leave medical information with my partner
__ Leave a message with detailed information

PRIMARY INSURANCE _____

INSURED_____
NAME RELATIONSHIP TO PATIENT DOB SOCIAL SECURITY #

SECONDARY INSURANCE _____

INSURED_____
NAME RELATIONSHIP TO PATIENT DOB SOCIAL SECURITY #

EMPLOYER _____

John M. Tieman, MD PA
Erika Kelso, FNP-C

NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO USE HEALTH INFORMATION

- Tieman Dermatology has made the Notice of privacy practices available to me
- Tieman Dermatology may access, collect, use and disclose my health information to my primary care or referring physician, to consultants and as necessary to others to process insurance claims, insurance applications and prescriptions.
- Tieman Dermatology may also disclose my health information to the following recipients unless otherwise indicated below:

_____

NAME PHONE RELATIONSHIP TO PATIENT

_____

NAME PHONE RELATIONSHIP TO PATIENT

__ MAY NOT release mental health record

__ MAY NOT release record containing communicable diseases (including HIV/ AIDS)

__ MAY NOT release records containing alcohol/drug abuse treatment

__ MAY NOT release other records: (please specify:_____

BILLING AUTHORIZATION

I authorize Tieman Dermatology to release information concerning my medical treatment to my insurance company as necessary for processing claims. I also authorize Tieman Dermatology to receive direct payment from my insurance company, including Medicare or Medicare Replacement Plan, for services rendered. I understand that I am responsible for any copayments, deductibles, or other charges for services that are not paid by my insurance. I understand that if I **do not have** insurance, the total cost of my services are due in full at the end of my appointment. This authorization is effective for all my records, including past records, and remains effective until it is revoked in writing

CANCELLATION POLICY

Because we reserve a time especially for you, we require a 24-Hour notice of cancellation. Please cancel before the 24-hour period to avoid the $25 late cancellation fee.

_____

SIGNATURE **DATE**

CRYOTHERAPY (FREEZING) POLICY

Cryotherapy is a treatment using liquid nitrogen to remove precancers, skin tags, warts, seborrheic keratosis, and skin growths by freezing them. Sometimes it can take 2-3 treatments before it clears.

What To Expect:

Liquid nitrogen is extremely cold. When sprayed on the skin the top skin layer rapidly freezes. When you leave the clinic, the freezing site will probably be red and swollen, and it may sting and itch as it thaws. Expect the site to feel like a bug bite. It may look worse over the next few days before it gets better. Swelling and/or blistering often develop within a day after treatment. 2-3 days after treatment a scab will probably form which will then take 7-10 days to fall off, leaving a pink smooth area.

I am aware of the following possible experiences/risks: There may be pain while the liquid nitrogen is applied and afterwards. The skin treated may become red and swollen. You may develop a blister (common), scar (rare), or a non-healing sore at a treatment area like the lower legs. Cryotherapy may cause your treated skin to lighten as it can damage pigment cells, leaving a white spot. It can also darken, leave a dark spot, if you have dark skin or get excessive sun to the area while healing. We recommend that you clean the area with soap and water daily and apply antibiotic ointment like Bacitracin until it heals. If this area is exposed to dirt, sweat, irritation from clothing or picking, cover daily with a Band-Aid.

Liquid nitrogen (freezing) is a procedure that will be filed with your insurance company. It is considered a procedure and will be applied to your deductible. If your deductible is not met, then the cost will be the patient's responsibility.

I understand that a claim for this procedure will be filed to my insurance company.

_____

Signature of Patient (or Patient Representative) **Date**

_____

Printed name of Patient (or Patient Representative) **Relationship to Patient**

HISTORY

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (enlarged prostate)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
Colitis or Crohn's disease
COPD
Coronary Artery Disease
Depression
Diabetes
Kidney Disease
GERD (Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other:_____

Past Surgical History: (please circle all that apply)

Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Colon surgery (Cancer, Colitis, Crohn's)
Gallbladder Removed
Coronary Artery Bypass
Heart Stents
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Pacemaker
Knee Replacement (Right, Left, Bilateral)
Hip Replacement (Right, Left, Bilateral)
Kidney Removed (Right, Left)
Kidney Transplant
Ovaries Removed (Cyst, Cancer)
Prostate Removed Cancer
TURP (prostate)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy (Cancer, Fibroids
Other:_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses (pre-cancer)
Basal Cell Skin Cancer
Blistering Sunburns
Eczema
Hay Fever/Allergies
Melanoma
Psoriasis
Squamous Cell Skin Cancer
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 Skin Cancer? Yes No
If yes, what type of skin cancer?_____
Which Relative(s)? _____

Medications: (If you have a list we will copy it)

_____
_____
_____

Medication Allergies: (Please enter all allergies to drugs)

_____
_____

Pharmacy: _____City_____

Primary Care Provider: _____ City_____

If you are female: Are you pregnant or trying to get pregnant**?** Yes No
Are you nursing or breastfeeding**?** Yes No

Social History: (Please circle all that apply)

Cigarette Smoking: Never Former smoker Occasional smoker Smokes daily

Alcohol Use: None Less than 1 drink/day 1-2/day More than 3/day

Preferred Language: English Spanish Other _____

Race: White/Caucasian Hispanic/Latino Asian

Black/African American Native American Other _____