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)

EMAIL ADDRESS: _____

☐ HOME # (_____) _____ ☐ CELL #_(_____) _____
CHECK IF PREFERRED CHECK IF PREFERRED

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** _____
POLICY NAME POLICY/SUBSCRIBER # GROUP #

INSURED _____
NAME RELATIONSHIP TO PATIENT DOB SOCIAL SECURITY #

**SECONDARY INSURANCE** _____
POLICY NAME POLICY/SUBSCRIBER # GROUP #

INSURED _____
NAME RELATIONSHIP TO PATIENT DOB SOCIAL SECURITY #

**EMPLOYER** _____

## 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): _____

This authorization is effective for all my records, including past records, and remains effective until revoked in writing.

## 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 is due in full at the end of my appointment.

## 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 of Patient or Guardian** **Date**

**Printed name of Patient or Guardian** **Relationship to Patient**

# CRYOTHERAPY (FREEZING) POLICY

Cryotherapy is a treatment using liquid nitrogen to remove precancers, skin tags, warts, seborrheic keratosis, and skin growth 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 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 Guardian** **Date**

_____

**Printed name of Patient or Guardian** **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:
_____

_____ _____ _____

**Printed name of Patient or Guardian** **Relationship to Patient** **Date**

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: _____

**Printed name of Patient or Guardian** **Relationship to Patient** **Date**