Dr. Mary Moore & Dr. Angel Puryear
7435 HWY 6, STE B
Missouri City, TX 77459
Phone: 832-342-9700
Fax: 832-342-9712

Intake and History Form

***Please present ALL Insurance cards and Drivers License to the receptionist.**

Patient Information: Please Complete All Fields Using Legal Names of the Parties Involved.

Name: (First)_____ (MI)_____ (Last)_____

Date of Birth: _____ Age: _____ Sex: _ Male _ Female Marital Status: Single Married Divorced Widow

Mailing Address: _____

City: _____ State: _____ Zip: _____ Social Security#: _____

Home Phone: _____ Cell: _____ Email address_____

Emergency Contact Name: _____ Phone#_____ Relationship _____

Pharmacy Name: _____ City: _____Phone#: _____

Primary Doctor Name: _____ City: _____Phone#: _____

Referring Physician _____City: _____ Phone#: _____

New Patients: How did you hear about us? _____

Primary Insurance Plan: _____ID#_____

Primary Insurance Plan Holder's Name: _____ DOB: _____ Relationship to patient: _____

Mailing address of Plan Holder if different from patient: _____

Home Phone of Plan Holder: _____ Cell phone of Plan holder: _____

Secondary Insurance Plan: _____ID#_____

Secondary Insurance Plan Holder's Name: _____ DOB: _____ Relationship to patient: _____

PATIENT RELEASE: MUST BE SIGNED BY PATIENT OR IF PATIENT IS A MINOR, THE LEGAL GUARDIAN

I certify that the information that I have provided is correct. I hereby consent to medical and surgical procedures, including but not limited to laboratory, biologic tests, & administration of local anesthesia which are deemed appropriate and necessary at any time while under the care of the physicians at Sienna Dermatology.

Tissue samples may be needed to diagnose your condition. Both malignant & benign growths and conditions may require a surgical procedure called a biopsy. It is the policy of this office to send all surgically removed specimens for expert consultation. Biopsies do not guarantee complete removal or that a diagnosis will be obtained. In a small percentage of cases, even with the biopsy information, a diagnosis may not be arrived at and another biopsy or special stain will have to be done. If the lab determines the lesion contains abnormal or cancerous cells additional treatment may be needed to ensure that no harmful cells remain. Biopsies carry minor risks such as: allergic reaction to anesthesia, bleeding, scarring, infection, and nerve damage. The risks of not having the procedure done should be discussed with your physician.

By signing below, I authorize Sienna Dermatology to administer care as is deemed necessary and access my full prescription history via Surescripts.

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ Date: _____

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Past Medical History

Select any of the following medical conditions you currently have:

- ☐ 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

_____
_____
_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____
_____
_____

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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?

○ 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?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____
_____

Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Reason for Today's Visit: _____
_____

How long has this problem been present ? _____

Have you tried any previous over the counter or prescription treatment for this condition?

SIENNA DERMATOLOGY

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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
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Occupation/Work place: _____

_____

Family History

Please include only first-degree relatives and their pertinent medical conditions:

_____

_____

_____

For Females Only

Are you pregnant? If yes, how many weeks?
Are you nursing?
Do you plan on becoming pregnant?
First Day of Last Menstrual Period

Review of Systems

Please circle if you are experiencing any of the following symptoms:

Constitutional
Fever or chills
Night sweats
Unintentional weight loss

Ear Nose and Throat
Nose bleeds
Sore throat
Difficulty swallowing
Shortness of breath
Cough/wheezing

Neurology
Headache
Seizures
Dizziness

Cardiology
Chest Pains
Palpitations

Urology
Blood in urine
Frequent urination

Endocrine
Thyroid problems

Allergy
Immunosuppression
Hay Fever

Ophthalmology
Eye irritation
Blurry vision

Gastroenterology
Diarrhea
Blood in stool
Abdominal pain

Psychology
Depression
Anxiety
Suicidal ideation

Musculoskeletal
Joint Aches
Neck stiffness
Muscle weakness

Hematology
Problems with bleeding

Signature:_____Date:_____

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Co-Payments, Deductibles and Co-insurances and Balances

- Copayments are due and collected on the day appointment. I understand I may be charged a $25.00 administrative billing fee for each co-payment that is not paid at the time of service.
- Sienna Dermatology will file claims with your insurance company, however, you remain responsible for your yearly deductible as well as any remaining copayment.
- All balances are due in full within 30 days of my first billing.
- Any balance left unpaid after 90 days without attempt at resolution will be considered for collections.
- I understand it is my responsibility to contact the office to arrange for an acceptable payment plan should I be unable to pay my balance in full.
- Should my account be sent to collections, I understand I will be responsible for an additional 15% administrative collection fee plus any attorney / court fees which may be added to my account during efforts to obtain payment.
- I am responsible for any bank fees associated with returned check fees plus a $25.00 administrative processing fee. Any returned check must be paid in full via credit card or cash within 15 days of notice or legal efforts to collect balance will be instituted.

Referrals

- It is my responsibility to know if my insurance plan requires a referral to see a specialist.
- If my insurance plan requires a referral, it is my responsibility to obtain an updated referral from my Primary Care Physician and to make sure Sienna Dermatology has the referral before my visit.
- I further understand that it is my responsibility to keep track of the number of visits I have used on my referral and the expiration dates of referrals and will obtain new ones as needed.
- I understand that should I fail to have a valid referral for my visit, Sienna Dermatology is not authorized to see me. I will either need to reschedule my appointment or pay in full at the time of service for my visit.
- If I decide to see the provider without my referral my insurance company will not reimburse me and I will be considered a self-pay patient for that visit and be responsible for the balance at the time of service.

Insurance Policies

- I will confirm my insurance is current at each visit. If there is a change to my insurance I will provide a valid insurance card or temporary print out at the time of my visit.
- If I am unable to produce this documentation, I will pay in full at the time of the visit and submit my claim to the insurance company for reimbursement or will need to reschedule my appointment.
- My insurance carrier may consider certain routine services in dermatology to be surgical in nature and separate co-insurances, deductibles or co-payments may apply. Each insurance plan is different, and I understand it is my responsibility to understand my policy and what will be covered. I also realize and understand that if there are any costs related to biopsy, pathology, cultures, or other lab work that my insurance carrier does not cover, that I am responsible for those costs.
- I understand in signing below that I am responsible for notifying Sienna Dermatology of any changes to my insurance or contact information. If insurance or referral information I present at the time of my visit is not correct, I will be responsible for all charges incurred.

Minor Patients

- A legal guardian MUST ACCOMPANY children under the age of 18 to their initial appointment so that proper forms can be completed, and your child can be treated.
- Children without legal guardian at their initial visit will be rescheduled.

Insurance Inquiries

- From time to time I may receive a letter from my insurance company requesting information about my coverage.
- I understand that claims will not be paid without my providing this information.
- I will reply to all insurance inquiries within 30 days of receipt or may be responsible for the entire balance.

Products: We are committed to providing quality products to our customers. While we hope that you are always satisfied with your purchases, we realize there are times that you may need to return a product. If you need to return your product, please review the information below:

*****Returns must be within 30 days of your receipt day for refund.
*Merchandise must be in its original, unopened, and unused condition

Prepaid Cosmetic Services:

All prepaid treatments must be used and/or in process according to treatment plan within one (1) year of purchase. Any unused treatments will expire, and no refunds will be issued. Failure to complete prepaid special package-priced treatments will default any credit back to regular pricing. Transfer of packages will be default to regular pricing prior to credit being issued to another account.

Refund policy:

Treatment, procedure, & service sales – All treatment, procedures, and services are final. Once a procedure has been provided, there are no refunds. Therefore, before a service is performed, please consider all the required protocols and side effects. Cosmetic services are elective and there are no guarantees as to the outcome results or patient satisfaction. We are committed to client satisfaction and are available to answer any questions or concerns you may have regarding the services we offer before purchase.

Patient or Legal Guardian Signature: _____ Date: _____

I agree to receive news and information about Sienna Dermatology via email, which may include offers and announcements for special events or offers from the practice and my physician. _____ (initial)

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Patient Name: _____

HIPAA Patient Authorization

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Sienna Dermatology from discussing appointments, medications, test results, or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are an adult college student away at school and you parents assist with prescriptions and appointments.
If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information about you. Should you wish to update the names below, please ask the receptionist for a HIPAA form.

Please place a check mark next to the following methods we may use to contact you regarding your appointments and medical information and indicate below any persons authorized to speak with our office on your behalf.

You may leave a message	**Regarding Appointments**	**Regarding Medical Results**
Home Answering Machine	_____	_____
Home# _____		
Mobile phone Voice Mail	_____	_____
Mobile # _____		
Information through email	_____	_____

Name of Individual (please print) **Relationship to Patient**

_____

Patient or Guardian Signature: _____ **Date:** _____

I acknowledge and understand the above HIPAA policies and understand I may request a copy of Sienna Dermatology's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

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OPTIONAL Credit Card on File for BALANCES after insurance

- We have implemented a policy for an optional credit card held on file. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured.
- Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit.
- Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share, you will receive a statement.
- At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.
- This is an advantage since it makes checkout easier, faster, and more efficient.
- This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

I, _____ authorize Sienna Dermatology, PLLC to charge my credit card for any outstanding patient responsible balances after applicable insurance reimbursements have been applied for medical services received at Sienna Dermatology, PLLC.

Relationship to the Patient: ☐ Self ☐ Parent/Guardian ☐ Other _____

Select one: ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Card Number: _____

Exp Date (mm/yy):_____

CVV: _____

- If your balance is over $100 you will receive a courtesy call

- Declined Transactions/Closed Accounts:

  - You will be notified by phone by our billing department to provide an alternate card for payment
  - A $25.00 service charge will be added to all accounts if no alternative payment is provided.
  - An additional monthly late fee charge of $25.00 will also be applied to any account that is 30 days past due from the date of the failed transaction.

Would you like to be emailed a receipt? ☐ Yes ☐ No Email address: _____

Would you like to keep your credit card information on file for future visits?

☐ Yes ☐ No

Name of Patient: _____

Signature: _____

Printed Name of Signature: _____