SOUTHSIDE DERMATOLOGY
MEDICAL ◆ SURGICAL ◆ COSMETIC
720 West 71st. St ● Tulsa, OK 74136 ● Phone 918-760-0700 ● Fax 918-628-0700

Patients First & Last Name _____ **Middle Initial**_____ **Nickname** _____
Date of Birth _____ **SS#** _____| _____ | _____ **Marital Status:** _____
Birth Sex:_____ **Gender Identity**_____ **Pronouns**_____
Address _____ **City** _____ **State** _____ **Zip** _____
Preferred Contact Method _____**Phone (Home)** _____ **(Work)** _____ **(Cell)** _____
Email _____ **Pharmacy (Name & Location)** _____

Is it okay to leave a voicemail on answering machine? □ Yes □ No **Is it okay to obtain prescription history from pharmacy? □ Yes □ No**

Is it okay for photographs to be taken for medical records only (we will NOT publish or use promotional purposes) □ Yes □ No
Primary Care Physician (First and last name) _____ **Referring Physician** _____

Emergency Contact _____ **Phone #** _____ **Relationship** _____

Parent or Guardian of Minor Children

Parent/Guardian Name _____ Date of Birth _____ Phone # _____

Address (if different than patients) _____City_____State_____Zip_____

INSURANCE INFORMATION

Primary Insurance Carrier _____
Member ID _____
Group Number _____

Secondary Insurance Carrier _____
Member ID _____
Group Number _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES AT TIME OF SERVICE.

I understand that I am responsible for all charges including deductible, co-pay's, etc. that are not covered by my insurance plan including Medicare. I authorize transfer of medical benefits to undersigned physician for services rendered. I authorize release of any medical information necessary to process this claim.

Please note: you may incur separate charges for laboratory services.

Patient Signature _____ **Todays Date** _____

Notice of Privacy Practices Patient Acknowledgement

I have received and understand the practice's Notice of Privacy Practices written in plain language. I understand that the practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Permission to Disclose Health Information

I grant permission for Southside Dermatology to discuss or release information concerning my medical diagnosis, or information relating to or in my medical records, or any medical information that the aforementioned entity may have on file as it concerns me including but not limited to billing, benefit inquiries, claims, and appeals and complaints, to the following individual/(s) in compliance with the required HIPAA guidelines:

Name: _____ **Relationship:** _____ **Name:** _____ **Relationship:** _____

Name: _____ **Relationship:** _____ **Name:** _____ **Relationship:** _____

Patient Signature _____ **Todays Date** _____

PATIENTS NAME_____ PATIENTS DOB _____

Past Medical History: (please circle all that apply or circle none)

Anxiety	Depression	High Cholesterol	Cancer:
Arthritis	Diabetes	Thyroid Problems	Type_____
Asthma	End Stage Renal Disease	Leukemia	Other: _____
Bone Marrow	Hearing Loss	Lymphoma	
Transplantation	Hepatitis	Radiation Treatment	**NONE**
COPD	High Blood pressure	Seizures	
Coronary Artery Disease	HIV/AIDS	Stroke	

Past Surgical History: (please circle all that apply or circle none)

Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass
Heart Transplant
Heart: Mechanical Valve Replacement

Joint Replacement, Hip, Knee (Right, Left, Bilateral)
Other: _____

Date:_____

NONE

Skin Disease History: (please circle all that apply or circle none)

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

Do you wear Sunscreen? □ Yes □ No **Do you tan in a tanning salon?** □ Yes □ No

Do you have a family history of Melanoma? □ Yes □ No If **yes**, which relative(s)? _____

Medications: (Please enter all current medications **or provide a list**)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

Cigarette Smoking: □ Current Smoker □ Former smoker □ Never smoked

For patients 65 and older: Have you received one or more pneumonia vaccination? □ **Yes** □ **No**

Have you had a Flu vaccine this season? □ **Yes** □ **No** If yes, which month? _____

Significant Immediate Family History: (Please list medical condition and which relative)

_____

_____

Review of Systems: Are you currently experiencing any of the following?

	Yes	No		Yes	No
Fever/Chills			Allergy to topical antibiotics		
Current Infection			Artificial heart valve		
Immunosuppression			Artificial joint replacement		
Nausea/Vomiting			Blood thinners		
Diarrhea or GI complaints			Defibrillator		
Shortness of Breath			MRSA		
Muscle aches			Pacemaker		
Joint aches			Require antibiotics prior to a surgical procedure		
Allergy to Adhesive			Rapid heartbeat with epinephrine		
Allergy to lidocaine			Currently pregnant or trying to get pregnant		

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Patient No-Show Policy

At Southside Dermatology, our goal is to provide all patients with timely, high-quality care. Missed appointments without prior notice prevent other patients from receiving care and disrupt our schedule. This policy outlines our expectations for appointment cancellations and no-shows.

A **$75 no-show fee** will be charged if the patient does not come to their appointment and does not notify our office.

*__Note:__ This fee is **not covered by insurance** and must be paid before future appointments can be scheduled.

Patients with **two (2) or more no-shows** within a 12-month period may:

- Be required to prepay for future appointments
- Be placed on a same-day or standby appointment basis
- Be subject to dismissal from the practice depending on the severity and frequency

***We understand that emergencies and unexpected situations occur. If you miss an appointment due to a genuine emergency, please contact our office as soon as possible to discuss the situation.**

_____ _____

Patient/Guardian Signature Date