Coastal Skin Care & Wellness Center
Gary F. Cox, M.D.
2705 Hospital Drive Suite 100 – Building B
Victoria, Texas 77901
361-579-4700

Patient Registration Form

Appointment Date: _____ Time: _____

Who referred you for today's visit? _____ Primary Physician_____

Are you seeking treatment because you were recently in an accident or were referred by an attorney? Yes_____No_____

Last Name: _____ First Name: _____

Middle Name: _____ Date of Birth: _____

Sex: M_____F_____ Social Security Number_____

Home Phone: _____Work: _____Mobile: _____

***Preferred Phone Number (check one) Home _____Work _____Mobile_____**

Mailing Address:_____

City: _____ State: _____ Zip Code: _____

Employer_____

Status: Single_____ Married_____ Other_____ Spouse Name_____

Email Address: _____

Responsible Party (This is where statements will be sent)

Name: _____Date of birth: _____SS#: _____

Address_____

Home Phone: _____ Mobile: _____ Work: _____

In case of emergency, please notify: (Someone not living with you)
Name_____Address_____
City_____State_____Zip_____Phone_____

Insurance Information

Primary Insurance _____

Primary Subscriber Name _____

Date of Birth: _____/_____/_____ Social Security Number_____

Patient Relationship to subscriber: Self_____ Child_____ Other_____ List relationship_____

Secondary Insurance: _____

Secondary Subscriber Name: _____

Date of Birth: _____/_____/_____ Social Security Number _____

Patient relationship to subscriber: Self_____ Child_____ Other _____List relationship _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. Payment is expected from you at the time of services, unless prior arrangements have been made. We accept all credit cards, including Care Credit for your convenience. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

_____ _____/_____/_____

Signature of Patient or Legal Guardian Date

Please read below and sign:

I agree to pay the physician for any balance due from myself or patient. I accept financial responsibility for and hereby consent to all surgical procedures and treatment, including, but not limited to laboratory and biologic tests and administration of anesthetics, which are deemed appropriate and necessary for treatment of the disorder about which I have consulted this office. I am also aware that a scar may result from any surgical procedure and the type of scar cannot be determined before surgery.

SIGNATURE OF AUTHORIZED PERSON certifies claim information and authorizes release of medical or other insurance information.

I DECLARE THE FOREGOING answers to be true and correct and hereby authorize the physician who has treated or attended the patient, to furnish the insurance company or the referring physician any information requested regarding treatment. Should an office visit or office surgical procedure need to be billed with patient's insurance (including Medicare and Medicaid), I HEREBY AUTHORIZE DIRECT PAYMENT TO THE PHYSICIAN.

_____ _____

Signature of Patient or Legal Guardian Date

Coastal Skin Care & Wellness Center

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information about you. The notice contains a patient's rights section describing your rights under the law. You have the right to review our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. You understand that we are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice has provided this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Copies of our Notice of Privacy Practices is available upon request.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

*May we phone, email, or send a text to you to confirm appointments?	YES	NO
*May we leave a message on your answering machine at home or on your cell phone?	YES	NO
*May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Physician Assistant Consent for Treatment

Coastal Skin Care & Wellness Center has Physician Assistants on staff to assist in the delivery of medical care.

A Physician Assistant is not a Physcian. A Physician Assistant is a graduate of a certified training program and is licensed by the State Board. Under the supervision of a Physician, a Physician Assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Physician Assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Performing surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (as allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Physician Assistant for my health care needs.

I understand that at any time I can refuse to see the Physician Assistant and request to see the Physician.

_____	_____
Patient's Name	Patient's Date of Birth
_____	_____
Patient's Representative's Name/Relationship	CSCWC Staff Member Signature
_____	_____
Patient/Representative Signature	Date

Dermatology Medical History

Patient_____ Date ____/____/____

Race: _____Ethnicity: _____Preferred Language:_____

Reason for today's visit: _____

Are you allergic to any medications? _____If so, what are you allergic to: _____

Are you allergic to Latex? _____ Are you allergic to Xylocaine? _____

List all current medical diagnoses (e.g. diabetes, depression, high blood pressure, etc):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List all medications you are currently taking (include vitamins, over-the-counter, and herbals):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal:		
Nausea/Vomiting	☐	☐
Diarrhea	☐	☐
Yeast infections	☐	☐
Arthritis	☐	☐
Arthralgia	☐	☐
Limited Motion	☐	☐
Artificial Joints	☐	☐
Convulsion, Epilepsy, or Seizures	☐	☐
Fainting	☐	☐
Hepatitis	☐	☐

List all surgical procedures you have had in the past:

_____

_____

_____

Skin:

Have you had skin cancer? _____If so, what type: _____

Family history of skin cancer: _____If so, what type: _____

Do you have any history of keloids (Overgrowth of scar tissue): _____

Social History:

Do you drink alcohol? _____If yes, how many drinks per day_____

Do you smoke? _____If yes, how many packs per day_____

Any history of IV drug use: _____Have you ever had or have you been exposed to HIV (AIDS):_____

Females:

Are you pregnant: _____ Last Menstrual Cycle: _____ Contraceptives: _____

Have you had a hysterectomy? _____Have you had a tubal ligation: _____

SUPPLEMENTAL PATIENT INTAKE FORM

Due to new requirements from the United States Department of Health and Human Resources, we are requesting that all patients complete the following questionnaire.

PATIENT NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: ☐ Male ☐ Female

Are you enrolled in Medicare Part B? ☐ YES ☐ NO

Do you have a Primary Care Physician ☐ YES ☐ NO

Primary care physician name: _____

Date of last visit with primary care physician_____

What is your preferred pharmacy? _____

If Applicable:

TOBACCO USE:

Please choose the option that best describes your tobacco use:

☐ Never ☐ Current smoker ☐ Previous smoker ☐ Less than 100 cigarettes in lifetime

For current tobacco users, select the option that best describes use:

☐ 1-3 cigarettes per day ☐ Up to 1 pack per day ☐ 1-2 packs per day ☐ 2 or more packs a day

If applicable:

ALCOHOL USE:

On a single occasion in the last year, how often have you had 4 *(females)* or 5 *(males)* drinks?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

VACCINATIONS:

Between January 1, 2017 and March 31, 2017 or October 1, 2017 and December 31, 2017 did you receive the following vaccine?

Flu vaccine: ☐ YES ☐ NO

Have you EVER received Pneumonia vaccine: ☐ YES ☐ NO