Lubbock Dermatology & Skin Cancer Center
Patient Information Sheet

*In order to provide quality care, we strive to have a complete and accurate medical history; therefore, please fill out the S-O-A-P medical records information form, also. Thank You!

Who is responsible for patient's medical expenses? (Guarantor/Parent)________________________

If patient is a minor; we need parent's information (if not listed above)**:**

Address: _________________________________City/State/Zip: _____________________________________

Social Security Number _______-______-_______ Date of Birth: ___________________ Sex: M_____ F____

Phone: Home ( ) __________________ Work ( ) ___________________ Cell ( ) _______________

Your Insurance Company:

Primary: _________________________________ **Secondary:** ___________________________________

NOTE: You must complete the above information and submit your insurance cards to be copied or we cannot file your insurance. Patients are responsible for meeting all insurance requirements and deductibles at the time of service. **Insurance referrals are the responsibility of the patient. This office does not provide payment plans. Please be prepared to pay in full at the end of your visit.**

Consent for treatment and release of information:
I consent to treatment by Richard Hope, M.D. and/or Justin Clark, M.D. and/or Chasidy Marquis, F.N.P. and/or Kristen Farquhar, P.A. and/or Jennifer Gamez, F.N.P. I also authorize the above mentioned to release, request, and/or obtain any or all of my medical information for consultation, referral and/or insurance purposes.

Assignment of Benefits: I authorize payment of medical benefits to the undersigned physician for services provided

Signed: ____**Date:** ________________________________

I authorize any subsequent treatment for my child, if I am unable to be here:

Name & relationship to patient: ____

Notice: You will receive three statements if a balance remains on your account.

____
Initial

(PLEASE COMPLETE THE OTHER SIDE)

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that a copy of this office's Notice of Privacy Practices is available to me at any time during normal business hours at the front desk. This document explains how my medical information may be disclosed.

_________________ ____

Date Signature of Patient/Parent/Guardian

If you wish for information to be released and/or discussed with a third party of your choice, please complete the following:

I, ________________________________, authorize Lubbock Dermatology, Dr. Richard Hope and/or Dr. Justin Clark and/or Chasidy Marquis F.N.P. and/or Kristen Farquhar, P.A. and/or Jennifer Gamez, F.N.P. and staff to release information regarding my health and medical treatment to the person(s) listed below.

__________________________________ ____________________________ _________________

Name Relationship to patient Phone Number

__________________________________ ____________________________ _________________

Name Relationship to patient Phone Number

____________________________ ____________________________

Patient Signature Date

AGREEMENT AS TO GOVERNING LAW AND FORUM: The patient and health care provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute any lawsuit, action of cause action which in any way relates to health care provided to patient shall only be brought in a Texas District Court in the county where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state or in any Federal Court. The choice of law and forum selection provisions of this paragraph is mandatory and are not permissive.

____ ___________________________

Signature of Patient/Parent/Guardian Date

Richard Hope, M.D.
Justin Clark, M.D.
Chasidy Marquis, F.N.P.
Kristen Farquhar, P.A.
Jennifer Gamez, F.N.P.

North Location
3601 22nd Street
Lubbock, Texas 79410
Office (806) 796-7193
Fax (806) 796-0034

South Location
5103 98th Street, Ste. 200
Lubbock, Texas 79424
Office (806) 796-7193
Fax (806) 368-8193

PATIENT HISTORY FOR S-O-A-P MEDICAL RECORDS SYSTEM

Please note that all the information is strictly confidential and cannot be accessed by other computer systems.

Date____________________

Last Name____________________

First Name____________________

Middle Name____________________

Date of Birth__________Gender__________

Occupation____________________

Lives with____________________
(i.e., alone, wife, husband, son, parents, etc.)

Social Security Number____________________

List all medications that you are currently taking. Include all medications prescribed by other physicians, over the counter medications, birth control pills, vitamins, and pain medications including aspirin.

❑ **See attached list provided by patient**

____
____
____
____
____
____
____
____
____

Street Address/P.O. Box____________________

City__________State__________

Zip Code____________________

Phone Numbers : Check Preferred #

❑ Cell (   )____________________

❑ Home (   )____________________

❑ Work (   )__________Place__________

Emergency (   )__________Contact__________

Primary Care Physician____________________

Referred by Name____________________
(❑ Physician ❑ Patient of Ours ❑ Other)

Preferred Pharmacy____________________

Allergies to medications? ❑ Yes ❑ No
If yes, please list drug and reaction

____
____
____
____
____

Do you...			**Daily Amount**
Smoke?	❑ **Yes**	❑ **No**	**How Much?**__________
Drink Coffee?	❑ **Yes**	❑ **No**	**How Much?**__________
Drink Alcohol?	❑ **Yes**	❑ **No**	**How Much?**__________
Take Supplements?	❑ **Yes**	❑ **No**	**How Much?**__________

COVID-19 Vaccine: Yes ___ No ___

(Please fill out the other side)

Reviewed ___

Please list all major medical problems. Also list skin problems for the past and present, including acne, psoriasis, skin cancer, etc.

Problem / Procedure	Date	Physician

Adult Immunizations **Date**

Shingrix ____________

Influenza (flu) ____________

Gardasil ____________

Please list health problems within your family

Father____________________

Mother____________________

Brothers/Sisters____________________

Children____________________

Review of Symptoms
(check any symptoms you have and make comment)

General / Endocrine: ❑ weight change ❑ fever ❑ sweating

Neurological / Psychiatric: ❑ headache ❑ crawling ❑ sensation

Heart / Respiratory: ❑ swollen ankles ❑ wheezing

Gastrointestinal / Genitourinary: ❑ nausea ❑ warts ❑ blisters

Hematologic / Lymphatic: ❑ swollen nodes ❑ painful nodes
❑ red streaking ❑ bleeding ❑ bruising

Allergic / Immunologic: ❑ hay fever ❑ asthma ❑ eczema

Skin: ❑ itching ❑ infection ❑ acne ❑ new growth ❑ rash ❑ warts

Do you have?

Artificial heart valves ❑ Yes ❑ No

Artificial Joints ❑ Yes ❑ No

Defibrillator Device ❑ Yes ❑ No

Have you had?

Rheumatic Fever ❑ Yes ❑ No

Mitral Valve Prolapse ❑ Yes ❑ No

Pediatric Immunizations

Are these up-to-date? ❑ Yes ❑ No

If not, which are lacking?____________________

Is there a family history of:

Skin Cancer ❑ Yes ❑ No Who?____________

Melanoma ❑ Yes ❑ No Who?____________Living?____

Atopic Disorders ❑ Yes ❑ No ❑ asthma ❑ hay fever ❑ eczema

Psoriasis ❑ Yes ❑ No Who?____________

Other Skin Disease ❑ Yes ❑ No

Who / What?____________________

What is bothering you <u>most</u> about your skin today?

____