HOPKINS DERMATOLOGY TEXAS
(682)271-0988

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____ _____

Age _____ Birthdate ___/___/___ SS# ___-___-___ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Race Ethnicity _____ Language _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

_____ _____

Referred By: Internet Friends/Family Magazine

Other _____

Hopkins
DERMATOLOGY

Dermatology Medical History

Patient: _____ Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list: _____

Have you ever had dental anesthesia (Novocain) or local anesthesia (Lidocaine)? ☐ YES ☐ NO
Any bad reaction? ☐ YES ☐ NO Explain, if yes: _____

List all medications you are currently taking** (including prescriptions, over-the-counter meds, vitamins, and herbals ex: cannabis**):
_____
_____

Primary Physician: _____ Referring Physician: _____
General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent Height: _____ Weight: _____

Do you currently have, or have you ever had any of the following diseases or conditions: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Tuberculosis	☐	☐
Shortness of Breath	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Bleeding Disorders	☐	☐
Prolonged Bleeding	☐	☐

Skin:	**YES**	**NO**
History of skin cancer	☐	☐
If yes, type: _____		
Family history skin cancer	☐	☐
If yes, type: _____		
History of specific skin diseases	☐	☐
Problems with healing	☐	☐
Excessive scarring/Keloids	☐	☐
Easy bleeding	☐	☐
Skin rashes	☐	☐
Reaction to Medications	☐	☐
Reaction to Food	☐	☐
Reaction to Environment	☐	☐
Sensitivity to Sunlight	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Lupus	☐	☐
Thyroid Disease	☐	☐
Kidney Disease	☐	☐
Bladder Infections	☐	☐
Connective Tissue Gastrointestinal	☐	☐
Stomach Disorder	☐	☐
Stomach Ulcers	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Convulsions	☐	☐
Epilepsy	☐	☐
Seizures	☐	☐
Fainting	☐	☐
Anxiety/Depression	☐	☐
Mental Disorder	☐	☐
Glasses or Contacts	☐	☐
Anemia	☐	☐
Stroke	☐	☐
Liver Disease	☐	☐
Cancer	☐	☐
Type: _____		

Social History:	**YES**	**NO**
Do you smoke/vape?	☐	☐
Do you drink alcohol?	☐	☐
If yes, _____ per day		
Do you use recreational drugs?	☐	☐
If yes, what? _____		

Infectious Diseases:	**YES**	**NO**
HIV/AIDS	☐	☐
Hepatitis A, B, or C	☐	☐
Syphilis/other sexually transmitted diseases	☐	☐

Females:	**YES**	**NO**
Are you pregnant?	☐	☐
Could you be pregnant?	☐	☐

Date of last menstrual cycle: ___/____/_____

Type of Birth Control: _____

Previous Pregnancies: _____
_____
_____
_____

Past Medical History: _____

_____

_____

Past Surgical History: _____

_____

_____

_____

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Dr. Hopkins of any changes in my medical condition or medications during my medical treatment or at follow up visits.

_____ _____ _____ _____
Reviewed By Date **Patient Signature** **Date Signed**

Hopkins
DERMATOLOGY

AUTHORIZED CONSENT

I accept full responsibility for services rendered and understand that payment in full is due at the time of service.

Please present insurance cards and photo ID to the receptionist so copies may be made.

I authorize and request that all insurance payments be made direction to Dr. Hopkins, should she elect to bill my insurance company and accept such payments.

I hereby authorize and consent Dr. Hopkins and Staff to:

1. **Evaluate and treat my medical conditions.**
2. **Call me at home or my place of employment regarding appointment reminders, lab results, or any other information pertaining to my care.**
3. **Leave a message on my answering machine with appointment reminders, or regarding lab results. (Results will not be left in the form of a message).**
4. **Send information to me in the mail, via text or email regarding appointments or patient education/information.**
5. **Release medical records to my referring or primary physician, and to my insurance company, if applicable.**
6. **If you have questions concerning the cost of a planned procedure, it is your responsibility to discuss this with the office manager or a staff member BEFORE the procedure is done. Payment of charges is required at the time of the office visit. WE ARE ONLY CONTRACTED WITH BLUE CROSS BLUE SHIELD, HUMANA, MEDICARE AND UNITED HEALTHCARE,. We will give you the proper forms to be submitted to your insurance company for reimbursement. Cosmetic procedures are not likely to be reimbursed by insurance and other fees may be reimbursed at reduced insurance fees; and therefore, all your expense may not be covered.**

*********WE DO NOT ACCEPT MEDICAID INSURANCE*********

At my request, discuss my medical condition or appointment with another member of my household/family?

☐ **Yes** ☐ **No**

If yes, whom: _____ **Relationship:** _____

Telephone #: _____

_____
Patient Signature

It is my responsibility to notify this office of any change in the above information. I understand that by signing this form I have read and understand my responsibility.

_____ _____
Signature **Date**

Hopkins
DERMATOLOGY

M. JANINE OSWALT HOPKINS, M.D.

Acknowledgement of Receipt of Notice of Health Information Privacy Practices

I, (Printed Patient Name)_____,
acknowledge receipt of the Notice of Health Information Privacy Practices.

By: (Patient Signature)_____

This_____day of_____ 20____.

321 West Southlake Blvd., Suite 180 Phone: 682-271-0988 Fax: 682-273-0538 www.hopkinsdermatology.com

Hopkins
DERMATOLOGY

HOPKINS DERMATOLOGY OFFICE FINANCIAL AGREEMENT

Welcome and thank you for choosing Hopkins Dermatology as your healthcare provider. Your clear understanding of our practice financial and office policies is important to our professional relationship. The following information outlines your responsibility related to payment and appointment reservations for professional services.

Insurance: We work to have your insurance verified at the time of your appointment. However, if we are unable to verify insurance coverage, it is the patient's responsibility to contact the insurance company directly with any questions regarding benefits and coverage.

Referrals and Preauthorization: It is your responsibility to understand your insurance benefits and obtain a referral from your Primary Care Physician if it is required. If the referral is not sent to us prior to your scheduled appointment, you will be asked to reschedule the visit until it is received. It is also your responsibility to obtain a preauthorization for services if required by your insurance company prior to your appointment.

Co-Payment: A co-payment is a dollar amount set by your insurance company which you are responsible for at each visit. Some insurance plans may also have co-insurance, in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible. All co-payments must be paid at the time of service.

Deductible: An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay. Deductibles are due at the time of service.

Self- Pay: Patients who do not have insurance or, insurance that we are contracted with, are considered self-pay. Payment in full is due at the time of service. Superficial Radiation Therapy patients are required to pay their patient responsibility at the start of their simulation appointment.

Missed Appointments: If you are unable to keep your appointment, please notify our office at least 48 hours in advance. Failure to provide this notice will result in a $75 no-show fee.

Dismissal from Practice: Please note that compliance with treatment plans (including medications and/or lab work), keeping recommended follow-up appointments is your responsibility. A patient that fails to follow recommended treatment plans, return phone calls or emails from the practice informing of pathology results, will relinquish Hopkins Dermatology of any adverse responsibility and will be released from care. Patients who repeatedly cancel or fail to show for appointments, exhibit inappropriate/abusive behavior towards staff may also result in dismissal from our practice.

Cosmetic Services: **Cosmetic or elective procedures such as removal of benign lesions or any service not covered or billed to insurance are considered self-pay**. We require a one-time cosmetic consultation with Dr. Hopkins. The fee for this consultation is dependent upon cosmetic inquiries and is not applied towards any treatment. A $200 deposit is required when scheduling an elective appointment. If you are unable to keep this appointment, please notify our office at least 48 hours in advance to cancel or reschedule. Failure to provide this notice will result in a $200 non-refundable fee.

Laboratory and Pathology Fees: It may be necessary to obtain a tissue sample or perform lab tests to confirm a diagnosis or determine a course of treatment. Specimens sampled are sent to outside laboratories to process, and fees associated with this service are separate from the procedure performed by your treatment provider. You may receive an additional bill for services by that lab that are not covered by your insurance. If you have identified as "self-pay" you shall be responsible for all fees incurred from the lab.

I, _____ acknowledge and accept the terms of this agreement.

_____ _____

Patient Signature **Date**

Hopkins
DERMATOLOGY

Are there any other services that you are interested in? Dr. Hopkins specializes in the following:

- ❑ Dermal Fillers & Injectables
- ❑ Trinity of Anti-Aging Injections
- ❑ Lip Injections
- ❑ Jawline Enhancement
- ❑ Tear Trough Injections
- ❑ Non-Surgical Liquid Facelift
- ❑ Liquid Necklift
- ❑ Anti-Aging Hand Injections
- ❑ Neurotoxins
- ❑ Botox
- ❑ Daxxify®
- ❑ Jeuveau
- ❑ Dysport®
- ❑ Xeomin
- ❑ Microneedling
- ❑ PRP Facials
- ❑ Geneo Facials
- ❑ Laser Hair Removal
- ❑ Skin Tightening
- ❑ Tightlase
- ❑ Cellulite Treatment with Aveli®
- ❑ TightSculpting
- ❑ Hormone Replacement Therapy
- ❑ PRP Injections for Laser Hair Restoration
- ❑ Acne
- ❑ Acne Scars
- ❑ Discoloration/Uneven Skin Tone
- ❑ Hyperpigmentation/Sun Damage
- ❑ Fine lines/Wrinkles
- ❑ Rosacea

---

*If you would like to further discuss these services, a cosmetic consultation is required which ranges from $150 - $225