Christine D. Brown, M.D., P.A.

3801 Gaston Avenue, Suite 302 ♦ Dallas, TX 75246 ♦ Phone (214) 828-0016 ♦ Fax (214) 828-4883

PATIENT INFORMATION (Please print clearly)

Patient's Name	Marital Status S M W Div Sep	Sex M F	Date of Birth	Social Security #
Street Address	City and State		Zip Code	Home Phone #
Patient's Employer	Occupation (indicate if student)			Cell Phone #
Employer's Street Address	City and State		Zip Code	Cell Provider ☐AT&T ☐Verizon ☐Sprint ☐T-Mobile ☐Other_________
Emergency Contact (not living with you)	Relationship			Emergency Contact Phone #
Spouse's Name	Occupation		Spouse Date of Birth	Spouse Contact #
Primary Care Physician	Physician Address			Physician Phone #
Who referred you to this practice?	Email Address			Drivers License Number

IF THE PATIENT IS NOT THE INSURED:

Responsible Party's Name	Marital Status S M W Div Sep	Sex M F	Date of Birth	Social Security #
Street Address	City and State		Zip Code	Home Phone #
Patient's Employer	Occupation (indicate if student)			Business Phone #
Employer's Street Address	City and State		Zip Code	Relationship to Patient

PRIMARY INSURANCE:

Name of Insurance Co.	Phone # (to verify benefits)	Phone # (for pre-certification)
Address	City and State	Zip Code
Name of Insured	ID #	Group #

SECONDARY INSURANCE:

Name of Insurance Co.	Phone # (to verify benefits)	Phone # (for pre-certification)
Address	City and State	Zip Code
Name of Insured	ID #	Group #

PHARMACY BENEFITS INFORMATION:

Preferred Pharmacy Name	Address or Location	Phone #

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS: I hereby authorize Christine D. Brown, M.D. to furnish appropriate and necessary details of medical information to my insurance company. I hereby authorize payment of medical benefits to Christine D. Brown, M.D. for medical services rendered.

Patient Signature: ____ Date: ______________________

Parent or Guardian: ______________________________________ Date: ______________________

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FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing our office for your care. We appreciate the opportunity to serve your health care needs and look forward to getting to know you. If you have any questions or concerns, please feel free to discuss these with our staff. Or philosophy is to provide personalized, high quality healthcare in the most cost-effective manner.

This form was developed to explain and clarify our financial policies. Please read this carefully and sign on the next page where indicated. Your signature indicates that you have read and understood our policies and that you will honor the terms. We appreciate your cooperation.

Standard Payment Policy:

Payment for our office visits is due at the time services are rendered. For your convenience, we accept VISA, MASTERCARD, and DISCOVER. We will provide you with an itemization of charges that you may submit to your insurance carrier for reimbursement of fees.

For Medicare patients, our office accepts assignment and files claims with Medicare. Medicare patients are responsible for any coinsurance and deductible amounts. Medicare patients must present their Medicare card at the time of registration. We do file secondary insurance for Medicare patients.

If you are an HMO/PPO (managed care) patient of a plan in which we participate, our office has agreed to accept the plan’s fee schedule and file the claim with your insurance company. HMO/PPO patients are responsible for co-pays and deductibles at the time of service. HMO/PPO patients must present their insurance card at the time of registration. HMO/PPO patients are responsible for obtaining a referral number from your primary care physician.

Payment Policy:

Mohs and other surgery patients: We file insurance claims (including Medicare) for all surgery patients. We inform you of estimated deductibles and co-insurance amounts. These amounts are due at the time of service. Any balance due from the patient that is still remaining once insurance has paid its portion will be billed to you.

Insurance Claims:

We make every effort to seek insurance reimbursement on covered services. Filing insurance is a service we provide to you; however, insurance is a contract between you and your carrier. Once your insurance company has paid, you will receive a bill for any remaining balance on the account.

Collection Efforts:

We work with you to make payment arrangements. If these efforts do not result in a resolution of the account, the account may be referred to a collection agency and the local credit bureau. Any collection fees incurred by our office are charged to your account. An 18 percent annual service charge is added to balances over 30 days old.

Returned Checks:

A service fee of $35.00 is charged on all returned checks. You will be afforded the opportunity to remit the total of the check plus the $35.00 fee in the form of cash, cashier's check, or money order on a timely basis. Our office policy is such that failure to comply with the above may result in your check being turned over to the Dallas County District Attorney's office for collection.

Missed or Cancelled Appointments:

If you do not appear for your appointment, or if you cancel your appointment with less than 24 hours' notice, you will be billed a $40.00 "missed appointment" fee.

"Not Medically Necessary" or "Cosmetic" Procedures:

Insurance companies have instituted restrictions on procedures and have designated these as "not medically necessary." Procedures that commonly fall into this category are listed below:

- Removal of benign lesions, including moles, warts, skin tags, cherry or spider angiomas, lentigines (liver spots), cysts, and seborrheic keratoses by any procedure.
- Collagen treatments
- Glycolic acid peels
- Surgery to repair a torn ear (due to earrings)
- Laser surgery for any benign lesion
- Sclerotherapy for leg veins
- Cautery for treatment of dilated blood vessels of the face

If you elect to continue with a procedure in this non-covered category, payment in full is required at the time the service is rendered. There is no reduction in our standard fee schedule for managed care of Medicare patients. Medicare patients will be required to sign a separate acknowledgement statement as required by Medicare guidelines. Our office does not file a claim with your insurance carrier when any of these procedures are performed.

I have read and understand the above and agree to comply with the financial policies of Christine D. Brown, M.D., P.A.

____

Signature of Patient (or parent) Date

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PATIENT INSTRUCTIONS

WAIVER

Please complete the enclosed information form prior to your appointment date and return it to us as soon as possible.

Include a **photocopy of the front and back of your insurance card(s)** and bring your insurance card(s) with you at the time of your appointment.

If you have an **HMO type plan**, be sure you have **a current referral from your primary care physician**. This will help us ensure that you see Dr. Brown at your scheduled appointment time. If you do not have **a valid referral** by the time of your appointment, **your appointment will be rescheduled**.

You will also need to bring **$2.00** in dollar bills or quarters (**exact change only**) in order to exit from the parking garage in our building.

Thank you in advance for your assistance in getting the medical information forms to us as soon as possible.

I have read and understand the information provided to me herein.

____

Signature of Patient (or parent)   Date

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Patient Preferences Regarding Communication of PHI (Patient Health Information)

Approved HIPAA Contacts

☐ **DO NOT disclose or discuss any information related to my billing account or medical conditions with anyone other than myself, except in an emergency situation.**

Please list any person(s) Dr. Brown and/or her office staff may contact and indicate (by checking the box) if we may discuss any information related to your billing account and/or medical conditions. Also, choose the person you would like us to list as your emergency contact in the event an emergency situation was to take place at our office.

Name ____________ Relationship ____________ Phone Number ____________

☐ Billing Account Information ☐ Medical Condition Information ☐ Emergency Contact

Name ____________ Relationship ____________ Phone Number ____________

☐ Billing Account Information ☐ Medical Condition Information ☐ Emergency Contact

Preferred Method of Communication

☐ **I request that communication regarding my medical conditions to occur only when I am in the office. Please only print and hand me information when I am in the clinic. I DO NOT wish to be notified my any other communications regarding my medical conditions.**
*****If you check the box above, we CANNOT call you, email you, or mail anything to you under any circumstances.**

My preferred contact method regarding my medical conditions is indicated below (check ONE only):

☐ Home Phone ☐ Work Phone ☐ Cell Phone
☐ Mailed Letter ☐ Guardian ☐ Other

Write the number in:
(   )   -

If the above method of communication is by phone, please check the appropriate box below:

☐ OK to leave a message with detailed information.
☐ Please leave a message with call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications including charges from your mobile carrier for calls or texts received.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you want us to call you at a different phone number for a particular test result.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed on this form will require my specific authorization prior to the disclosure of any medical information.

______________________________ ______________
Signature of Patient, Parent, or Legal Guardian Date

______________________________ ______________
Name of Legal Guardian Relationship to Patient

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Social History Questionnaire

Do you drink alcohol? ☐ Yes or ☐ No

Amount: _____ servings per week Type: __________

Do you use illegal drugs? ☐ Yes or ☐ No

Do you smoke or use tobacco products? ☐ Yes or ☐ No

Amount: _____ packs per day Type: __________

Have you ever had skin cancer? ☐ Yes or ☐ No

What type? ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Other: _____________

Has anyone in your family had skin cancer? ☐ Yes or ☐ No

Family Member(s): ____

What type? ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Other: _____________

Do you have a history of any skin disease? ☐ Yes or ☐ No

Have you ever been exposed to HIV (AIDS)? ☐ Yes or ☐ No

Do you have artificial joints? ☐ Yes or ☐ No

Have you ever had dental anesthesia? ☐ Yes or ☐ No

Do you bleed easily? ☐ Yes or ☐ No

Do you have medication allergies? ☐ Yes or ☐ No

(Women) Are you pregnant? ☐ Yes or ☐ No

Height: _____________ Weight: _____________

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other: _________

Please list your occupation: ____

Do you have occupational exposure to chemicals or petroleum? ☐ Yes or ☐ No

Do you have occupational exposure to arsenic? ☐ Yes or ☐ No

Occupational sun exposure: ☐ Mild ☐ Moderate ☐ Severe

Recreational sun exposure: ☐ Mild ☐ Moderate ☐ Severe

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Medical History

Please check the box marked "**Current**" if you are **currently experiencing problems** with any of the conditions below. Please check the box marked "**Past**" if you have **previously been diagnosed** with any of the conditions below. Please check the box marked "**Family Hx**" if the **condition runs in your family** and **indicate which family member**.

Cardiovascular	Current	Past	Family Hx/member
Artificial Valves	☐	☐	☐ _______
Chest Pain	☐	☐	☐ _______
Defibrillator	☐	☐	☐ _______
Pacemaker	☐	☐	☐ _______
Palpitations	☐	☐	☐ _______
Heart attack	☐	☐	☐ _______
Heart disease history	☐	☐	☐ _______
Heart murmurs	☐	☐	☐ _______
High cholesterol	☐	☐	☐ _______
High blood pressure	☐	☐	☐ _______
Irregular heartbeat	☐	☐	☐ _______
Rheumatic fever	☐	☐	☐ _______
Stroke	☐	☐	☐ _______

Constitutional	Current	Past	Family Hx/member
Fever	☐	☐	☐ _______
Chills	☐	☐	☐ _______
Weakness	☐	☐	☐ _______
Fatigue	☐	☐	☐ _______
Weight change	☐	☐	☐ _______
Alcoholism	☐	☐	☐ _______
Cancer	☐	☐	☐ _______
Chemical dependency	☐	☐	☐ _______

Endocrine	Current	Past	Family Hx/member
Abnormal thyroid	☐	☐	☐ _______
Diabetes	☐	☐	☐ _______
Heat or cold intolerance	☐	☐	☐ _______
Excessive thirst/hunger	☐	☐	☐ _______
Excessive sweating	☐	☐	☐ _______

Ears/Nose/Mouth/Throat	Current	Past	Family Hx/member
Dizziness	☐	☐	☐ _______
Headaches	☐	☐	☐ _______
Earaches	☐	☐	☐ _______
Hearing difficulty	☐	☐	☐ _______
Hearing ringing in ears	☐	☐	☐ _______
Vertigo	☐	☐	☐ _______
Motion sickness	☐	☐	☐ _______
Blurred vision	☐	☐	☐ _______
Cataracts	☐	☐	☐ _______
Color blindness	☐	☐	☐ _______
Eye pain	☐	☐	☐ _______
Excessive tearing	☐	☐	☐ _______
Glaucoma	☐	☐	☐ _______
Macular degeneration	☐	☐	☐ _______
Vision loss/Blindness	☐	☐	☐ _______
Nasal congestion	☐	☐	☐ _______
Nasal drainage	☐	☐	☐ _______
Nosebleeds	☐	☐	☐ _______
Sinus problems	☐	☐	☐ _______
Bleeding gums	☐	☐	☐ _______
Dry mouth	☐	☐	☐ _______
Hoarseness	☐	☐	☐ _______
Sore tongue	☐	☐	☐ _______
Sore throat	☐	☐	☐ _______
Teeth problems	☐	☐	☐ _______

Gastrointestinal	Current	Past	Family Hx/member
Abdominal pain	☐	☐	☐ _______
Colon cancer	☐	☐	☐ _______
Constipation	☐	☐	☐ _______
Diarrhea	☐	☐	☐ _______
Heartburn/Reflux	☐	☐	☐ _______
Indigestion	☐	☐	☐ _______
Nausea	☐	☐	☐ _______
Trouble swallowing	☐	☐	☐ _______
Vomiting	☐	☐	☐ _______
Bowel problems	☐	☐	☐ _______
Cirrhosis	☐	☐	☐ _______
Colitis	☐	☐	☐ _______
Gallbladder disease	☐	☐	☐ _______
Hepatitis	☐	☐	☐ _______
Hernia	☐	☐	☐ _______
Hemorrhoids	☐	☐	☐ _______
Liver disease	☐	☐	☐ _______
Rectal problems	☐	☐	☐ _______
Stomach problems	☐	☐	☐ _______
Stomach ulcer	☐	☐	☐ _______
Yellow jaundice	☐	☐	☐ _______

Genitourinary	Current	Past	Family Hx/member
Bedwetting	☐	☐	☐ _______
Blood in urine	☐	☐	☐ _______
Flank pain	☐	☐	☐ _______
Incontinence	☐	☐	☐ _______
Kidney stones	☐	☐	☐ _______
Pelvic pain	☐	☐	☐ _______
Urinary infection	☐	☐	☐ _______
Bladder problems	☐	☐	☐ _______
Gallbladder disease	☐	☐	☐ _______
Kidney disease	☐	☐	☐ _______
Kidney stones	☐	☐	☐ _______
Prostate problems	☐	☐	☐ _______
Vaginal infections	☐	☐	☐ _______
Venereal disease	☐	☐	☐ _______

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Medical History (Continued)

Hematological	Current	Past	Family Hx/member
Blood transfusions	☐	☐	☐ ________
Clotting problems	☐	☐	☐ ________
Anemia	☐	☐	☐ ________
Bleeding disorders	☐	☐	☐ ________
Leukemia	☐	☐	☐ ________
Phlebitis	☐	☐	☐ ________

Immunologic	Current	Past	Family Hx/member
AIDS/HIV positive	☐	☐	☐ ________
Allergy	☐	☐	☐ ________
Allergy treatment	☐	☐	☐ ________
Chicken pox	☐	☐	☐ ________
Hay fever	☐	☐	☐ ________
Measles	☐	☐	☐ ________
Mononucleosis	☐	☐	☐ ________
Organ transplants	☐	☐	☐ ________
Typhoid fever	☐	☐	☐ ________

Integumentary	Current	Past	Family Hx/member
Skin Color changes	☐	☐	☐ ________
Dryness	☐	☐	☐ ________
Hair/nail changes	☐	☐	☐ ________
Itching	☐	☐	☐ ________
Keloid tendency	☐	☐	☐ ________
Melanoma	☐	☐	☐ ________
Skin cancer	☐	☐	☐ ________
Sores	☐	☐	☐ ________
Rashes	☐	☐	☐ ________
Warts	☐	☐	☐ ________
Herpes	☐	☐	☐ ________
Hives or eczema	☐	☐	☐ ________
Scarlet fever	☐	☐	☐ ________
Ulcers	☐	☐	☐ ________

Musculoskeletal	Current	Past	Family Hx/member
Arthritis	☐	☐	☐ ________
Back pain	☐	☐	☐ ________
Joint pain	☐	☐	☐ ________
Joint redness	☐	☐	☐ ________
Joint swelling	☐	☐	☐ ________
Loss of motion	☐	☐	☐ ________
Muscle pain	☐	☐	☐ ________
Muscle weakness	☐	☐	☐ ________
Spine surgery	☐	☐	☐ ________
Stiffness	☐	☐	☐ ________
Joint deformity	☐	☐	☐ ________
Bone/joint disease	☐	☐	☐ ________
Gout	☐	☐	☐ ________
Multiple sclerosis	☐	☐	☐ ________

Neck	Current	Past	Family Hx/member
Carotid bruit	☐	☐	☐ ________
Carotid surgery	☐	☐	☐ ________
Goiter	☐	☐	☐ ________
Lumps	☐	☐	☐ ________
Neck pain/stiffness	☐	☐	☐ ________
Swollen glands	☐	☐	☐ ________

Neurologic	Current	Past	Family Hx/member
Fainting	☐	☐	☐ ________
Numbness/Tingling	☐	☐	☐ ________
Paralysis	☐	☐	☐ ________
Seizures	☐	☐	☐ ________
Stroke	☐	☐	☐ ________
Tremors	☐	☐	☐ ________
Dizziness	☐	☐	☐ ________
Epilepsy	☐	☐	☐ ________
Migraines	☐	☐	☐ ________
Motion sickness	☐	☐	☐ ________
Meningitis	☐	☐	☐ ________
Polio	☐	☐	☐ ________

Psychiatric	Current	Past	Family Hx/member
Anxiety	☐	☐	☐ ________
Bipolar	☐	☐	☐ ________
Dementia	☐	☐	☐ ________
Depression	☐	☐	☐ ________
Mood changes	☐	☐	☐ ________
Nervousness	☐	☐	☐ ________
Tension	☐	☐	☐ ________
Hx of Psych care	☐	☐	☐ ________
Mental disorder	☐	☐	☐ ________
Nervous disorder	☐	☐	☐ ________

Respiratory	Current	Past	Family Hx/member
Asthma	☐	☐	☐ ________
Bronchitis	☐	☐	☐ ________
COPD	☐	☐	☐ ________
Cough	☐	☐	☐ ________
Emphysema	☐	☐	☐ ________
Pneumonia	☐	☐	☐ ________
Shortness of breath	☐	☐	☐ ________
Tuberculosis	☐	☐	☐ ________
Wheezing	☐	☐	☐ ________
Influenza	☐	☐	☐ ________
Pleurisy	☐	☐	☐ ________
Tuberculosis	☐	☐	☐ ________
TB exposure	☐	☐	☐ ________

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Medical History (Continued)

When listing items here, please print clearly in black ink.

Please list any allergies to medications:

____
____
____

Please list all medication that you take (include dosage and frequency):

____
____
____

Please list all surgeries and corresponding dates:

____
____
____

Including:

- ☐ Internal Cardiac Defibrillator Date: ________________
- ☐ Heart-valve Replacement Date: ________________
- ☐ Pacemaker Insertion Date: ________________
- ☐ Venous Filter Date: ________________
- ☐ Cardiac/Vascular Stent Date: ________________ Location: ____________________
- ☐ Coronary Arterial Bypass Graft Date: ________________ Location: ____________________
- ☐ Heart Transplantation Date: ________________
- ☐ Lung Transplantation Date: ________________
- ☐ Liver Transplantation Date: ________________
- ☐ Kidney Transplantation Date: ________________
- ☐ A-V Fistula Date: ________________
- ☐ Synthetic Vascular Graft Date: ________________
- ☐ Total Joint Replacement Date: ________________ Location: ____________________
- ☐ Shunt Date: ________________ Location: ____________________
- ☐ Orthopedic Hardware Implant Date: ________________ Location: ____________________
- ☐ Other Implant Date: ________________ Location: ____________________