Hill Country Dermatology
Vicente Quintero, MD PA

We are changing our system to Electronic Medical Records. We will need the following information based on Government Requirements.

Patient Registration (please print)

Name: _____ D.O.B.____/____/____ □ Male □ Female
Last First MI

Address: _____
Street City State Zip

SSN#:_____ Marital Status: S M W D Married to: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred Method of Contact: □ Home Phone □ Cell Phone □ Email

Preferred Pharmacy: _____

How did you hear about us: □ Doctor Referral □ Website □ Facebook □ Friend Referral □ Drove By
□ Other _____

Preferred Language: □ English □ Spanish Other: _____

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

If Patient is a Minor**,** list Parent(s) Name: _____

Emergency, Contact: _____
Name Relationship Phone

Referring Physician: _____Phone#_____

Primary Care Physician: _____Phone#_____

INSURANCE INFORMATION:
Patients Relationship to the Insured (policyholder): □ Self □ Spouse □ Child □ Other_____

Primary Insurance_____ _____ Secondary Insurance_____

Policyholder (if different than patient): D.O.B._____/_____/_____ SSN: _____

_____
Last Name First MI Phone

Address: _____
Street City State Zip

*** I authorize the release of medical information to my primary care physician, referring physician and/or insurance company as necessary to coordinate care and process claims. I will be responsible for any services which are deemed not covered by my insurance (even if my claim is processed out of network). I authorize Hill Country Dermatology to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Hill Country Dermatology and myself.

I understand that payment is due in full at the time services are provided.

Signature: _____Date:_____/_____/_____

Hill Country Dermatology
MEDICAL HISTORY

Reason for today's visit: _____ Date of Onset Symptoms: _____/_____/_____

	PATIENT PAST MEDICAL HISTORY		(Details)	FAMILY PAST MEDICAL HISTORY		(Affected Family Member)
Abnormal Bleeding/Clotting	Yes	No	_____	Yes	No	_____
Adopted	Yes	No	_____	Yes	No	_____
Asthma	Yes	No	_____	Yes	No	_____
Autoimmune Disorder	Yes	No	_____	Yes	No	_____
Cancer (*Specific Type*)	Yes	No	_____	Yes	No	_____
Diabetes	Yes	No	_____	Yes	No	_____
Eczema	Yes	No	_____	Yes	No	_____
Heart Disease	Yes	No	_____	Yes	No	_____
Hepatitis	Yes	No	_____	Yes	No	_____
High Blood Pressure	Yes	No	_____	Yes	No	_____
Hives	Yes	No	_____	Yes	No	_____
Kidney Disease	Yes	No	_____	Yes	No	_____
Liver Disease	Yes	No	_____	Yes	No	_____
Malignant Melanoma	Yes	No	_____	Yes	No	_____
Skin Cancer	Yes	No	_____	Yes	No	_____
Skin Disease	Yes	No	_____	Yes	No	_____
Stroke	Yes	No	_____	Yes	No	_____
Thyroid Disorder	Yes	No	_____	Yes	No	_____
Tuberculosis	Yes	No	_____	Yes	No	_____
Ulcers	Yes	No	_____	Yes	No	_____

List any other diseases or conditions: _____

SURGERY: List any surgical procedures in the past 6 months
Surgery: _____ Date: ___/___/____ Surgery: _____ Date: ___/___/____

SKIN HISTORY:
Do you have a history of any specific skin disease? □ Yes □ No If yes, _____
Do you develop keloids (scars) after surgery? □ Yes □ No
Do you bleed easily? □ Yes □ No
Do you develop skin rashes in reaction to: □ Medications □ Food □ Environment □ Bandages □ Topical Neosporin?

SOCIAL HISTORY:
Do you drink alcohol? □ Yes □ No If yes: □ socially □ daily
Smoking Status: □ Never Smoker □ Current Smoker □ Former Smoker
Do you have a history of STD? □ Yes □ No If yes explain: _____
Have you had or have you been exposed to HIV (AIDS)? □ Yes □ No

List any/all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals):
1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

Have you had the Influenza vaccine? □ Yes □ No If yes, received at: □ Pharmacy/Home □ Work
Have you had the Pneumococcal vaccine? □ Yes □ No
Are you allergic to any medications? □ Yes □ No If yes, _____
Have you ever had dental anesthesia (Novocain)? □ Yes □ No If yes, any bad reaction? □ Yes □ No
Nausea, vomiting, diarrhea when taking antibiotics? □ Yes □ No Yeast infection when taking antibiotics? □ Yes □ No

FEMALE QUESTIONS:
Do you have irregular periods? □ Yes □ No If yes, explain: _____
Are you pregnant or planning to get pregnant? □ Yes □ No If pregnant, how far along are you? _____
Are you breastfeeding? □ Yes □ No □ N/A

Patient Name: _____ Signature: _____ Date: _____/_____/_____