



Today's Date ___/___/___

Mary Ana Cunningham, M.D.
Jennifer Aranda, M.D.

DIPLOMATS OF THE AMERICAN BOARD OF DERMATOLOGY

PATIENT INFORMATION

(Please Print)

Name _____ Date of Birth ___/___/___ Age ___ Sex ___
Last First M.I.
Mailing Address _____ City State Zip
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____ Would you like to receive our newsletter? Yes or No
Marital Status _____ Dr. License Number _____ SS# _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____ Date of Birth ___/___/___ Age ___ Sex ___
Last First M.I.
Mailing Address _____ City State Zip
Home Phone _____ Work Phone _____ Cell Phone _____
Dr. License Number _____ SS# _____ Employer _____

INSURANCE INFORMATION (Please present insurance card at time of check in).

Primary Insurance

Name _____ Subscriber Name _____ Sub. DOB ___/___/___ Relationship to insured _____
Sub: SS# _____ Employer Name _____ Employer Phone _____

Secondary Insurance _____

Other family members that are patients? _____

In case of Emergency, who should be notified? _____ Phone _____

Referred by: _____

Primary Care Physician _____ Phone _____

Pharmacy of choice _____ Phone _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician. For those patients with insurance, applicable copayments, deductibles and co-insurance will be collected at the time services are rendered. Payment is required for all services at the time they are rendered unless previous arrangements have been made. We accept payment in the form of cash, check or credit card. I understand that in the event my account is turned over to a collection agency, collection fees and/or attorney fees will be added to my account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____

Date ___/___/___



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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Lakeway Dermatology's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Printed Name—Patient or Representative

Relationship to Patient (If other than patient)

Signature

Date

Release for Leaving Results on Answering Machine or With Representative

I give permission for my lab results to be left on my answering machine/voice mail at the number below or with my representative listed below. The authorization will remain in effect until revoked in writing.

Phone Number with Area Code

Name of Representative

Signature

Date

For Guardians of Minor Patients Only:

Parent or guardian must accompany patient who is under the age of 18 for INITIAL visit.
For Follow-up visits please choose one of these **two options:**

1. I authorize Dr. Cunningham to see my child on follow-up visits without my presence.

Signature: _____ Date: _____

2. I will be present for all follow-up visits.

Signature: _____ Date: _____

This authorization will remain in effect until revoked in writing.



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We would like to extend a warm welcome to you. Our goal is to provide you with the highest level of dermatology care and service.

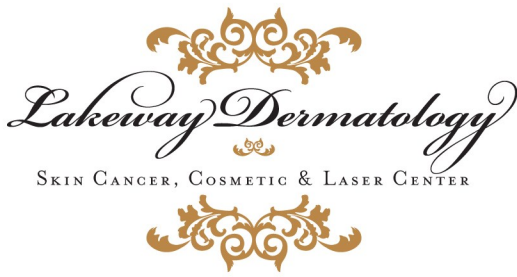
In order to serve you well and to avoid misunderstandings, we would like to inform you of our office policies:

- *Please remember that the filing of your insurance is a service to you and does not substitute for payment.* In the event your insurance company has not paid our office within 90 days, your account balance will be transferred from insurance responsibility to patient responsibility.
- If you have a deductible, payment for services that fall under the deductible is expected at the conclusion of your appointment. We accept cash, check, MasterCard and Visa.
- A \$25 fee will be assessed for returned checks.
- If copies of your medical records are needed, we require a signed release form. There is a \$20 fee for this service. Texas law allows the doctor's office 15 days to provide copies of your record.
- We require *24-hour notification* if you are unable to come for any type of office visit or procedure. As a courtesy, we call to remind you of your appointment one day in advance. However, you are still responsible for the appointment, even if we are unable to contact you. We understand that unforeseen events can occur such as illness or emergencies, but kindly give us a call if you're unable to keep your appointment time.

We greatly appreciate your understanding and cooperation.

I have read and understand the above policies and agree to their terms.

Name _____ Date _____



Patient Questionnaire

Date: _____

Name: _____

DOB: ___/___/___ Age: _____ Sex: _____

Marital Status: _____ Occupation: _____

Review of Body Systems:

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Yes	No	
		Acne
		Anemia
		Arthritis
		Asthma
		Bleeding Tendency
		Bone Disease
		Chronic Kidney Disease
		Depression or Mental Problems
		Diabetes
		Eczema, skin rashes or itching
		Hay Fever
		Heart Disease, Murmurs or Rheumatic Fever
		Heart Valve Replacement
		Hepatitis Which Type?
		Herpes (cold sores, shingles or genital)
		High Blood Pressure
		HIV or AIDS
		Hormone imbalance
		Joint Replacement
		Keloids or Excessive Scarring
		Liver Disease
		Lung Disease
		Lupus
		Melanoma Where?
		Other Cancer Of What Origin?
		Pacemaker/Defibrillator
		Psoriasis
		Seizures or Epilepsy
		Skin Cancer Where?
		Stomach Ulcers
		Swollen Feet or Ankles
		Thyroid Disease
		Tuberculosis
		Warts

Have
ever

For Female Patients:		
1. Pregnant?	Yes	No
2. Planning Pregnancy?	Yes	No
3. Breast Feeding?	Yes	No
4. Oral Contraceptives?	Yes	No
5. Regular Periods?	Yes	No
For All Patients:		
1. Do you smoke?	Yes	No
2. How many alcoholic beverages do you consume weekly?	<u>0</u> <u>1-5</u> <u>6-12</u> <u>12+</u>	
3. Do you use sunscreen?	Yes	No
	SPF _____	
Is there a family history of:		
1. Melanoma?	Yes	No
2. Other Skin Cancer?	Yes	No
3. Allergies/Asthma	Yes	No
4. Psoriasis	Yes	No

you
had:

List all major medical problems:

List all surgeries and procedures (including dermatological and cosmetic):

Do you have any known medication allergies? Yes No
If yes, please list drug and reaction

List all your medications including over the counter medications, birth control pills, vitamins & pain medications.
