Hill Country Dermatology
Vicente Quintero, MD PA

******* PLEASE COMPLETE ALL INFORMATION *******

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

Patient Registration (please print) **Page 1 of 2**

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 Pharmacy: _____

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

Preferred Method of Contact:
Home Phone
Cell Phone
Email

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

Emergency, Contact: _____
Name **Relationship** **Phone**

Referring Physician: _____Phone#_____

Primary Care Physician: _____Phone#_____

INSURANCE INFORMATION: (please present insurance card and driver's license to be copied at check in)
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 Dr. Vicente Quintero 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 Dr. Vicente Quintero 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: ___/___/____

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 or 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. _____

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: ____/____/____