

# CLEAR LAKE DERMATOLOGY

NARIN "DR. JOE" APISARNTHANARAX, M.D., FA.A.D

PRAPAND APISARNTHANARAX, M.D., F.A.C.P.

450 Medical Center Blvd., Suite 309 Webster, TX 77598

Telephone (281)332-9681 \* Fax (281)332-5957

[www.ClearLakeDerm.com](http://www.ClearLakeDerm.com)

## Patient Registration Form

Please Print Clearly and Fill in All The Blanks!!!

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address (Apt # if any): \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Email: \_\_\_\_\_

Pt Sex: Female / Male Pt.DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: Single / Married / Divorced / Widowed

Pt. Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

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Insured Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Insured SSN \_\_\_\_\_ D.O.B. \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Membership / Group No. \_\_\_\_\_

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Person To Notify In Emergency \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Referring Physican: \_\_\_\_\_ Allergies: \_\_\_\_\_

How did you find our office? \_\_\_\_\_ Provide names if referral is friend or relative \_\_\_\_\_

**Release & Assignment of Benefits:** I hereby authorize the release of any & all medical information to my insurance carrier(s) for purposes necessary to process any & all insurance claim(s) filed on my behalf & for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of Clear Lake Dermatology, PLLC. I understand that I am financially responsible to the charges incurred by myself or my dependents.

**Consent to Treat:** I hereby consent to treatment by Clear Lake Dermatology, PLLC to include examination, treatment, prescribing medication and skin preparations.

Signed \_\_\_\_\_

Date \_\_\_\_\_

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**Medical History**

Patient Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Visit: \_\_\_\_\_ Referred by: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
(if different from Referring Physician above)

Telephone: \_\_\_\_\_

Do you have any drug allergies? Y N If yes, please list: \_\_\_\_\_

Have you ever had any reaction to local anesthetics? Y N If yes, please explain: \_\_\_\_\_

List all prescription and non-prescription medications you are currently taking:

Y N Are you currently pregnant or breastfeeding?

Y N Alcohol Use? How much and how often? Y N Tobacco Use? Types and amounts used per day?

Please circle appropriate letter if you have a history of, or are currently under treatment for, the following conditions (if there is "Y," please explain on lines below):

- |                             |                                           |                                |                         |
|-----------------------------|-------------------------------------------|--------------------------------|-------------------------|
| Y N Heart Problems          | Y N Hepatitis (A,B,C)                     | Y N Organ Transplant           | Y N High Blood Pressure |
| Y N Diabetes                | Y N X-ray Therapy                         | Y N Ultraviolet Light Therapy  | Y N Skin Cancer         |
| Y N Pacemaker/Defibrillator | Y N Kidney Problems                       | Y N Psychiatric Condition      | Y N Keloids             |
| Y N Stroke                  | Y N Arthritis                             | Y N Currently Pregnant/Nursing | Y N Cancer              |
| Y N Blood Clots             | Y N Epilepsy                              | Y N Rheumatic Fever            | Y N Glaucoma            |
| Y N Bleeding Problems       | Y N Mitral Valve Prolapse                 | Y N Artificial Joint/Valve     | Y N Hair Loss           |
| Y N Acne                    | Y N Lung/Breathing Problems               | Y N Thyroid Disease            | Y N Asthma              |
| Y N HIV                     | Y N Require antibiotic prior to procedure |                                |                         |

Other: \_\_\_\_\_

Y N Previous Surgery? If yes, explain type of surgery and give dates (mo/yr) of each surgery:

Y N Do you have a family history of skin cancer? If yes, who in the family had skin cancer (relationship)?

Y N Do you have a family history of melanoma? If yes, who in the family had melanoma (relationship)?

\_\_\_\_\_  
Signature of Patient (responsible party & relationship if patient is a minor)

\_\_\_\_\_  
Date

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## Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Please initial each of the following numbered items:

1. \_\_\_\_\_ If we participate with your insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill your primary insurance plan. You will be responsible at the time of service for the payment of:
  - The annual deductibles
  - Co-payments
  - Charges for non- covered or cosmetic services
  
2. We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be balance billed if:
  - Your insurance company pays less than what we expected
  - We obtain a denial from your insurance company
  - We have not received payment from the insurance company within 60 days of filing your claim
  
3. \_\_\_\_\_ We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:
  - The annual deductibles
  - Co-payments
  - Charges for non-covered or cosmetic services
  - Secondary insurance portions that are not ordinarily forwarded by Medicare
  
4. \_\_\_\_\_ If you have no health insurance, payment is expected in full at the time of service.
  
5. \_\_\_\_\_ There will be a **\$25.00** service fee charged to your account if your check is returned by your bank for any reason. Upon notification from our office of your returned check, payment of the entire balance is due immediately.
  
6. \_\_\_\_\_ We kindly request that you give us 24 hours notice if you are unable to keep your appointment. Failure to give 24 hours notice will result in a **\$25.00** missed appointment fee. Cosmetic and surgical appointments are subject to a **\$50.00** missed appointment fee. This fee is not covered by your insurance plan.
  
7. We require **\$100.00** deposit on all cosmetic appointment procedures except consultations.

If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operation:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner or provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure performed by your authorization while it was in effect. Unless you give us written authorization, we cannot use or discuss your health information for any reason except those described in this Notice.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and healthcare operations):

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Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home. \_\_\_\_\_

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":  
Y/N

Can confidential messages (i.e., appointments reminders) be left on your telephone answering machine or voicemail?  
Y/N

I have read and understand Notice of Privacy Practice for Clear Lake Dermatology, PLLC.

Patient Name (guardian if under 18 years) \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Cosmetic Interest Questionnaire

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

*We offer cosmetic products and procedures for a variety of skin problems. If you would like to discuss treatments for any cosmetic needs and conditions, please check items below.*

<ul style="list-style-type: none"><li><input type="checkbox"/> Exercise and diet resistant fat</li><li><input type="checkbox"/> Cellulite and body shaping</li><li><input type="checkbox"/> Aging lines / wrinkles (frown lines, forehead lines, crow's feet, bunny lines, whistler's lines)</li><li><input type="checkbox"/> Tired and aged appearance</li><li><input type="checkbox"/> Reduction of lower face lines around the nose and mouth</li><li><input type="checkbox"/> Volume loss of the skin that occurs with aging</li><li><input type="checkbox"/> Sagging cheeks</li><li><input type="checkbox"/> Gummy smile</li><li><input type="checkbox"/> Add volume and definition to the lips</li><li><input type="checkbox"/> Slimmer jaw line</li><li><input type="checkbox"/> Dullness and roughness of skin</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Redness / red blood vessels</li><li><input type="checkbox"/> Brown spots / Sun spots / Aging spots</li><li><input type="checkbox"/> Acne</li><li><input type="checkbox"/> Scars</li><li><input type="checkbox"/> Large pores</li><li><input type="checkbox"/> Oily skin</li><li><input type="checkbox"/> Dry skin</li><li><input type="checkbox"/> Easy bruising</li><li><input type="checkbox"/> Darkness under the eyes</li><li><input type="checkbox"/> Tattoo Removal</li><li><input type="checkbox"/> Sunscreen advice / Sun damage</li><li><input type="checkbox"/> Thinning and losing hair volume</li><li><input type="checkbox"/> Excessive hair growth or unwanted hair (face, underarms, bikini lines, arms, legs, back)</li></ul>
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*If you would like to discuss any products and services in particular, please check them below:*

<ul style="list-style-type: none"><li><input type="checkbox"/> CoolSculpting – Fat Reduction</li><li><input type="checkbox"/> Laser hair removal</li><li><input type="checkbox"/> Laser tattoo removal</li><li><input type="checkbox"/> IPL photofacial</li><li><input type="checkbox"/> Fraxel laser resurfacing</li><li><input type="checkbox"/> Botox / Dysport</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Injectable fillers (Juvederm, Restylane, Radiesse)</li><li><input type="checkbox"/> Liquid face lift</li><li><input type="checkbox"/> Elta MD Sunscreen products</li><li><input type="checkbox"/> Skin-care advice and products</li><li><input type="checkbox"/> Clarisonic Pro / Opal</li></ul>
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