

**Colleyville Dermatology**  
**Sreedevi Kodali, M.D., 5209 Heritage Avenue, Suite 220, Colleyville, TX 76034**  
**Phone (817) 868-1616 — Fax (817) 868-1617**

**WELCOME**

Appt. Date & Time: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Welcome to Colleyville Dermatology. Thank you for choosing us for your dermatological needs. We have enclosed your new patient paperwork to allow you to complete it and return within 7-10 days after receipt of this packet. Please note, if a patient is under 18 years of age, a parent or guardian must complete paperwork and attend the appointment with the minor. If the patient is 18 years of age or older, the patient must complete his/her own paperwork. We are required to update your paperwork every year even if there are no changes. We do appreciate your cooperation with this matter.

We are located at 5209 Heritage Avenue, Suite 220 in Colleyville, TX 76034. We can be reached at (817) 868-1616. Our office hours are Monday through Thursday, 8:00 AM – 5:00 PM (with lunch from 12:00 – 1:00 PM) and Friday from 8:00 AM – 12:00 PM.

After you have completed your patient paperwork, please return it to us in the envelope provided. Please allow 5-7 business days for us to receive and scan your paperwork into our system. If there is not enough time to mail your paperwork back, please be sure that we have your insurance information, and bring your paperwork with you to your appointment.

We are looking forward to meeting you, and if you have any questions, please don't hesitate to call us at (817) 868-1616.

Thank you,

Dr. Sreedevi Kodali

# PATIENT REGISTRATION

## Patient Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Sex: \_\_\_\_M \_\_\_\_F Marital Status: \_\_\_\_\_  
\_\_\_\_\_  
Patient's SS #: \_\_\_\_\_  
Pt's Driver's License #: \_\_\_\_\_  
Home # (\_\_\_\_) \_\_\_\_\_ Primary Doctor: \_\_\_\_\_  
Office/Cell # (\_\_\_\_) \_\_\_\_\_ Primary Dr's #: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Employer's #: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_  
Pharmacy Information: \_\_\_\_\_

## Primary Insurance Information

Name of Insurance Company: \_\_\_\_\_  
Provider Customer Svc #: (\_\_\_\_) \_\_\_\_\_ Benefits/Claims #: (\_\_\_\_) \_\_\_\_\_  
Claims Address listed on Insurance Card: \_\_\_\_\_  
\_\_\_\_\_

ID # (member #): \_\_\_\_\_ Group or Plan #: \_\_\_\_\_  
Insured Party's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Insured Party's Date of Birth: \_\_\_\_\_ Insured Party's SS#: \_\_\_\_\_  
Insured Party's Employer: \_\_\_\_\_ Insured Party's phone # \_\_\_\_\_

## Secondary Insurance Information

Name of Insurance Company: \_\_\_\_\_  
ID or Member #: \_\_\_\_\_ Group or Plan #: \_\_\_\_\_  
Customer Service Phone #: (\_\_\_\_) \_\_\_\_\_ Benefits/Claims #: \_\_\_\_\_  
Claims Mailing Address listed on Insurance Card: \_\_\_\_\_  
\_\_\_\_\_

ID or Member #: \_\_\_\_\_ Group or plan #: \_\_\_\_\_  
Insured Party's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Insured Party's Date of Birth: \_\_\_\_\_ Insured Party's S.S.#: \_\_\_\_\_  
Insured Party's Employer: \_\_\_\_\_ Insured Party's phone #: \_\_\_\_\_

## Emergency Contact Information

Name of Emergency Contact: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Home #: (\_\_\_\_) \_\_\_\_\_ Alternate phone #: (\_\_\_\_) \_\_\_\_\_

Name of Second Emergency Contact: \_\_\_\_\_  
Relationship with patient: \_\_\_\_\_  
Home #: (\_\_\_\_) \_\_\_\_\_ Alternate phone # (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Patient/Legal Guardian or Authorized Person's (POA) Signature

\_\_\_\_\_  
Date

**Medical Questionnaire**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**Referred by:**

Dr. (name) \_\_\_\_\_ Family Member (name) \_\_\_\_\_  
 Friend (name) \_\_\_\_\_ Yellow Pages \_\_\_\_\_  
 Newspaper \_\_\_\_\_ Other \_\_\_\_\_

**Medical History:** Reason for visit: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Symptoms (How does it bother you?) \_\_\_\_\_

Treatments you have tried: \_\_\_\_\_

Please list all medications you are currently taking, including over-the-counter medication: \_\_\_\_\_

Please list any drugs you are allergic to: \_\_\_\_\_

**Medical problems (check if yes)**     Diabetes     High Blood Pressure     Heart disease     Pacemaker  
 Artificial joint/valve     Asthma     other Lung disease     Thyroid disease     Anemia  
 Hepatitis, type \_\_\_\_     HIV     other Liver disease     Lupus     Kidney disease  
 Cancer, type \_\_\_\_     Depression     History of long-term steroid use     X-Ray therapy  
 Other (comments): \_\_\_\_\_

**Past Surgeries/Medical problems**

**Pregnant:**  yes  no ( \_\_\_\_\_ weeks) Number of past pregnancies: \_\_\_\_\_

**History of Skin Cancer?**  yes  no:     Melanoma     Basal cell carcinoma     Squamous cell carcinoma

Area of body: \_\_\_\_\_ How treated: \_\_\_\_\_

**History of Skin Disease, past or current:** \_\_\_\_\_

**When you are exposed to sunlight, do you (check most applicable one):**

- |  |  |   |
|--|--|---|
| 1. <input type="checkbox"/> always burn              | 3. <input type="checkbox"/> often burn, tan slowly   | 5. <input type="checkbox"/> rarely burn, always tan |
| 2. <input type="checkbox"/> usually burn, rarely tan | 4. <input type="checkbox"/> sometimes burn, tan well | 6. <input type="checkbox"/> never burn, deeply tan  |

**Review of Systems (please check which of the following symptoms you are currently having):**

<input type="checkbox"/> Prone to infection	<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Stuffy Nose
<input type="checkbox"/> Weight change	<input type="checkbox"/> Eyelid scale	problems	<input type="checkbox"/> Sinus Pain
<input type="checkbox"/> Fever/Sweats		<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mouth sore/throat pain
		<input type="checkbox"/> Faint	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Penile/vaginal pain
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Cough/wheezing	<input type="checkbox"/> Abdomen pain	<input type="checkbox"/> Penile/vaginal discharge
		<input type="checkbox"/> Bowel change	<input type="checkbox"/> Menstrual irregularity
<input type="checkbox"/> Lymph node swelling	<input type="checkbox"/> Weakness of body parts	<input type="checkbox"/> Joint/muscle pain	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Numbness of body	<input type="checkbox"/> Back pain	<input type="checkbox"/> Change in urination freq.
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Seizures	<input type="checkbox"/> Skin growths	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Rash	<input type="checkbox"/> Itchy skin	<input type="checkbox"/> Hair/nail problems	<input type="checkbox"/> Bad scars (keloids)
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Skin sores		<input type="checkbox"/> Skin Color changes

**Past Family and Social History:** Is there a family history of (please circle): melanoma, skin cancer, asthma, eczema, hay fever, psoriasis, hair loss, diabetes, adult acne, genetic diseases ? Other: \_\_\_\_\_

Patient occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Animals in the home? \_\_\_\_\_

Smoker?    Yes    No    If yes, how many packs per day: \_\_\_\_\_

Number of alcoholic drinks per week: \_\_\_\_\_

History of past IV drug abuse, blood transfusions, or unprotected intercourse?    Yes    No

# Colleyville Dermatology

## Assignment of Insurance Benefits and Release of Information

I authorize the release of information necessary to process any claim. I certify that this information is true and correct to the best of my knowledge.

I authorize payment of medical benefits to be made on my behalf, to Colleyville Dermatology. I hereby authorize photocopies of the form to be recognized as valid as the original.

### Consent to Treat

I authorize medical procedures to be performed on the patient named below at the direction of Dr. Sreedevi Kodali, Colleyville Dermatology.

### Signature on File

I acknowledge that I have read and agree to be bound by the terms stated above. This signature shall be valid for one year, unless revoked by me in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

## **Important Notice!**

If this section is **NOT** filled out and signed, our office will only release information to the patient or guardian.

### Release of Information to Someone Other Than Myself

I authorize Colleyville Dermatology to release medical, appointment, and/or financial information over the telephone and/or to release copies of my medical records to the following person:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security Number: \_\_\_ XXX \_\_\_ - \_\_\_ XX \_\_\_ -  (required for identification purposes only)

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name (please print) \_\_\_\_\_

# Colleyville Dermatology

## Patient Financial Policy

We are committed to providing you and your family with the best possible care. In order to achieve this, we want you to understand our financial policy. Below we have provided detailed information pertaining to this policy. All, or only some of the policy may apply to you and your current situation and may also depend on what you are being seen for.

- ❑ We are providers for many managed care plans. We will file claims for those plans we participate in, and will require you to pay your copay/deductible/coinsurance at the time of the visit. Please be advised, if we have not heard from your insurance company within 60 days, the balance will become the patient's responsibility. If you have a biopsy or excision, your tissue will be sent to an outside laboratory for analysis. They are a separate entity from our office and you may receive a bill for their services.
- ❑ The majority of procedures done in the office are considered outpatient surgery, and may have a different benefit than an office visit. For example, if the doctor performs a procedure, it is likely that the insurance company will first applied it to the patient's deductible, once the deductible is met, the insurance company will pay their ratio portion (e.g. 80/20), and the patient owes the balance.
- ❑ Not all services are medically necessary. Some insurance companies arbitrarily select service they will not cover. You are responsible for these services. We must emphasize that as medical care providers, our relationship is with you and not with your insurance company.
- ❑ Payment for any cosmetic procedures is due at the time the service is rendered. The doctor will inform you, to the best of her knowledge, what procedures are deemed "cosmetic" by most insurance companies. However, the doctor does get very busy and may not convey this information, therefore it is a good idea to ask the doctor before a procedure is performed.
- ❑ We make every effort to help you with your referral from your primary care physician (if one is required), however it is the patient/guardian's responsibility to confirm that we have a current valid referral. Physicians are permitted to treat ONLY the condition(s) listed on the referral.
- ❑ We will file Medicare and a secondary or supplemental policy. You will receive a bill for any services approved by Medicare , but not paid by your secondary or supplemental plan. This is true also for other primary and secondary insurances.
- ❑ Full payments for services are due at the time services are rendered for all self-paying patients (patient's with either no insurance, or we are out of network with insurance). We accept cash, checks, Visa and MasterCard. A self-pay patient will be given a detailed receipt, which includes all pertinent information for you to send to your insurance company.
- ❑ We are NOT providers for MEDICAID and will only accept MEDICAID patient's as self-pay. We will NOT file any claims to MEDICAID as primary or secondary insurance.

If you have any questions regarding this financial policy, please don't hesitate to contact us.

---

Signature

---

Date

**Colleyville Dermatology  
Sreedevi Kodali, M.D.  
5209 Heritage Avenue, Suite 220  
Colleyville, TX 76034**

**Phone (817) 868-1616  
Fax (817) 868-1616**

## **Receipt of Notice of Privacy Practices Written Acknowledgement Form**

I, \_\_\_\_\_, have received a copy of Colleyville Dermatology's Notice of Privacy Practice.

\_\_\_\_\_  
Signature or patient/guardian

\_\_\_\_\_  
Date