DERMATOLOGY
OF NORTH TEXAS
Dr. R Terry Garbacz, DO

Patient Registration

Full Name: _____ Today's Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: _____ Marital Status: _____ SSN: _____

Phone (H): _____ (C): _____ (W): _____

Email Address (necessary for patient portal): _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____/Student/Retired/Other:_____ Race: _____ Ethnicity: _____

Preferred pharmacy Name: _____

City or Zip code:_____

Responsible party (Minors):_____Phone Number:_____

Relationship: _____ Address: _____

Insurance Subscriber: _____

If not self, please provide:

Name: _____ Date of Birth: _____ SSN: _____

Address (if different):_____

Phone number: _____ Relationship to Patient: _____

Statement of Financial Responsibility

I voluntarily consent to receive medical treatment and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to R. Terry Garbacz, DO, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medication information to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization in writing. **I understand that I am financially responsible for all incurred charges regardless of whether or not they are covered by insurance.**

Patient Name: _____ Signature:_____ Date: _____

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Patient Name: _____

History and Intake Form

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?
_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other
_____

Past Medical/Surgical History: (please circle all that apply and indicate type/date if applicable)

*Joint Replacement, **Knee** (Right, Left, Bilateral) Date: _____
*Joint Replacement, **Hip** (Right, Left, Bilateral) Date: _____
*Joint Replacement within last 2 years
*Transplant recipient: _____ Date:_____
*Implanted Device: _____ Date: _____
*Personal History of Cancer: _____

NONE

Other: _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma (date/surgeon):
_____
_____
_____
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other
_____

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Patient Name: _____

History and Intake Form Continued

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Sun Protection

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

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