Upon arrival to our office we ask that you provide proof of   
insurance to our receptionist. If you present the wrong   
information and your claim is denied, you will have to file any   
claims for treatment already performed.   
   
IF YOU REQUIRE A REFERRAL FROM YOUR PRIMARY   
CARE PHYSICIAN, AND ARE UNABLE TO PRESENT IT AT   
CHECK-IN, WE WILL NEED TO RESCHEDULE YOUR   
APPOINTMENT.   
  
  
  
  
Wallis Dermatology Associates PLLC is not contracted with the following:

BC/BS HMO Tricare-All

Care Improvement Plus ChampVA

Cigna –HealthSpring Scott & White

Texas Community Care

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES   
   
   
I have reviewed this office'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.   
   
   
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 Signature of Patient or Legal Guardian   
   
   
   
   
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 Name of Patient or Legal Guardian Date

WHO IS YOUR PRIMARY CARE PHYSICIAN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE?

Commercial\_\_\_\_\_\_ Internet\_\_\_\_\_\_ Facebook \_\_\_\_\_\_ Patient \_\_\_\_\_\_ Referring Physician \_\_\_\_\_\_

WE WILL ONLY FILE INSURANCE FOR YOU IF YOU ARE WITH A MANAGED CARE   
PLAN. OTHERWISE, YOU, THE PATIENT, WILL PAY IN FULL AND FILE ON YOUR OWN INSURANCE.   
   
PLEASE LET US COPY ALL INSURANCE CARDS. FULL PAYMENT IS REQUIRED IF   
INSURANCE INFORMATION IS NOT PRESENTED NOW.   
   
To My Insurance Carriers:   
   
1. I authorize the release of any medical information necessary to process my insurance   
 claim(s).   
2. I authorize and request payment of medical benefits directly to my physician.   
3. I agree that this authorization will cover all medical services rendered until such authorization   
 is revoked by me.   
4. I agree that a photocopy of this form may be used in lieu of the original.   
5. I hereby assign benefits due from my Medicare supplement policy for services rendered by   
 Mark S. Wallis, M.D., Alyn D. Hatter, D.O., Jason L. Blaser M.D., H. Scott Osborne, PA-C,

Tammi Short RN-FNP-C, Rachel Smith, PA-C,, or Charity Burkhardt PA-C, to the doctor.   
   
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 Signature of Patient or Representative Date   
   
 ASSIGNMENT AND RELEASE   
I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_   
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 Name of Insurance Company(ies)   
   
and assign directly to Dr. Mark S. Wallis all insurance benefits, if any, otherwise payable to me for   
services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.   
   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 Responsible Party Signature Relationship Date

CONFIDENTIALITY NOTICE   
 It is my understanding that by initializing this statement I give Dr. Wallis’ office my consent to   
leave information about my medical condition and/or appointment information with individuals   
who may answer the phone at the phone numbers I have provided, or they may leave messages   
on my answering machine at the numbers I have provided until I say otherwise.   
   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (This applied to anyone 18 years or older)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission to speak with the individuals listed below about any and all of my healthcare given by Wallis Dermatology Associates.

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medical History Questionnaire

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History (Check all that apply)**

No pertinent past medical history \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autoimmune Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_ are you insulin dependent? \_\_\_\_\_\_\_\_

Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis or Liver Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Memory Loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pacemaker/Defibrillator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Planning Future Pregnancy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant \_\_ Due Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Radiation Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin History (Check all that apply)**

No significant skin history \_\_\_\_

Abnormal Moles \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acne \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Actinic Keratosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Basal Cell Carcinoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eczema/Childhood eczema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Malignant Melanoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Suspicious Lesion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psoriasis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rosacea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Squamous Cell Carcinoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urticaria/Hives \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History-Afflicted Family Member**

No Relevant Family History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unknown \_\_\_\_ Adopted \_\_\_\_\_\_

Autoimmune Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lung Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Malignant Melanoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Surgical History**

No Past Surgeries or Hospitalizations \_\_\_\_\_\_\_\_\_\_\_

The following surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

*Alcohol* *Recreational Drugs*

Denies alcohol use \_\_\_ Denies drug use \_\_\_\_\_\_

Alcohol use socially\_\_\_ Admits drug use \_\_\_\_\_

# Drinks per week \_\_\_\_

*High Risk Factors*

Have you ever used a tanning bed? \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a severe sunburn? \_\_\_\_\_\_\_\_\_\_

**Smoking Status**

Never Smoker \_\_\_\_\_\_ Current Smoker \_\_\_\_\_\_\_

Former Smoker \_\_\_\_\_ Quit date \_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in any smoking cessation information?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Cancer**

None \_\_

Personal History of Skin Cancer \_\_\_

Personal History of Melanoma \_\_\_

Family History of Skin Cancer \_\_\_