UT SOUTHWESTERN MEDICAL CENTER

Department of Dermatology

To Our Valued General Dermatology Patients

Thank you for Choosing UT Southwestern. We want to welcome you to our practice and have listed some points below to make your experience with us all you expect it to be. As you know, we are a teaching institution, so please be aware that you may be seen by more than one physician as well as a Resident of our Dermatology Residency program.

- We try to see you as soon as possible and try not to turn anyone away. Unfortunately emergencies do occur and require time for assessment and treatment that may put the physician behind schedule.
- Your dermatologist will review your history with you and perform an examination. Your initial visit may last 30 to 45 minutes.
- Please arrive 30 minutes early for your appointment. If you arrive more than 20 minutes late, you will likely need to reschedule your appointment. Please have all new patient paper work completed when you arrive for your appointment. It is important that you bring these documents to your visit.
- Please bring your completed paperwork with you to your scheduled appointment. Failure to have the paperwork completed prior to the appointment results in a delay in seeing your provider.
- MyChart (mychart.utsouthestern.edu) can be used to request or cancel appointments and communicate with our clinic. If you want to enroll in MyChart, please let the receptionist know.
- ***Be sure that when departing clinic you have sufficient refills left on your prescriptions to carry you through to the next visit.*** This will diminish the likelihood that you will need to phone our office for refill requests. That said, please do not run out of your medications. You may request your prescriptions to be refilled via MyChart, or your pharmacist may fax a refill request to us at 214-645-2405. Please allow 48 hours for faxed prescription refills to be processed. Please note, we do not fill prescription after hours or on weekends.
- For mail order or 90 day supply prescriptions, please let your Physician or the Nurse know before your prescription is written.
- Please allow 7-10 business days for us to receive, review and notify you about your biopsy/lab results. Depending on what you and your Physician discussed during your visit, you may receive your results by letter or telephone.
- For urgent matters, contact the clinic at 214-645-2400. We have a Physician on call 24 hours a day who can be reached at this same telephone number.
- Our clinic has nursing staff to manage your telephone calls. However because our Nurses have many active responsibilities, that may not be immediately available at the time of your call. We do take pride in returning telephone calls within the same day. Please provide appropriate contact information not only at the time of your visit, but also when leaving a request for a Nurse to return your call.
- ***In general, it is best to have questions answered at the time of your clinic visit.***

Professional Office Building 2
5939 Harry Hines Blvd. 4th Flr./Dallas TX 75390-9191/75390-9192/214-645-2400/Fax 214-645-2405
www.utsouthwestern.org

We hope this summary gives you a better understanding of what to expect about our clinic. We want to make your experience a positive one and are always looking for ways to do things more efficiently. If you have suggestions, we appreciate your input. Should you receive a survey in the mail, please complete it and mail it back in the envelope provided.

Medical Information:

Please complete the enclosed information sheets and bring them (along with any relevant medical records) with you for your appointment.

Medical Insurance:

Our clinic does require payment at the time of service. Relatedly, if our practice accepts your insurance, please note that you will be required to pay your portion of incurred professional fees (i.e., office visit co-pays, percentage above insurance coverage, deductible, or other financial obligations). For your convenience, we accept checks, MasterCard, Visa, Discover, and American Express in addition to cash.

HMO/PPO patients please note: It is your responsibility to ensure that all referrals required for your visits are complete. **Please contact our office by telephone at 214-645-2400 or through MyChart prior to your appointment to ensure we have received your referral and/or authorization.** If you are not sure whether you need an authorization, please contact your primary care physician's office. **Please remember that a scheduled appointment in our clinic does not necessarily mean that your insurance company has authorized the visit. Also, please note, that if a referral is not received in our office within 20 minutes of your appointment time, your appointment will need to be rescheduled.**

Parking:

Valet or garage parking are available adjacent to our clinic building for a nominal fee.

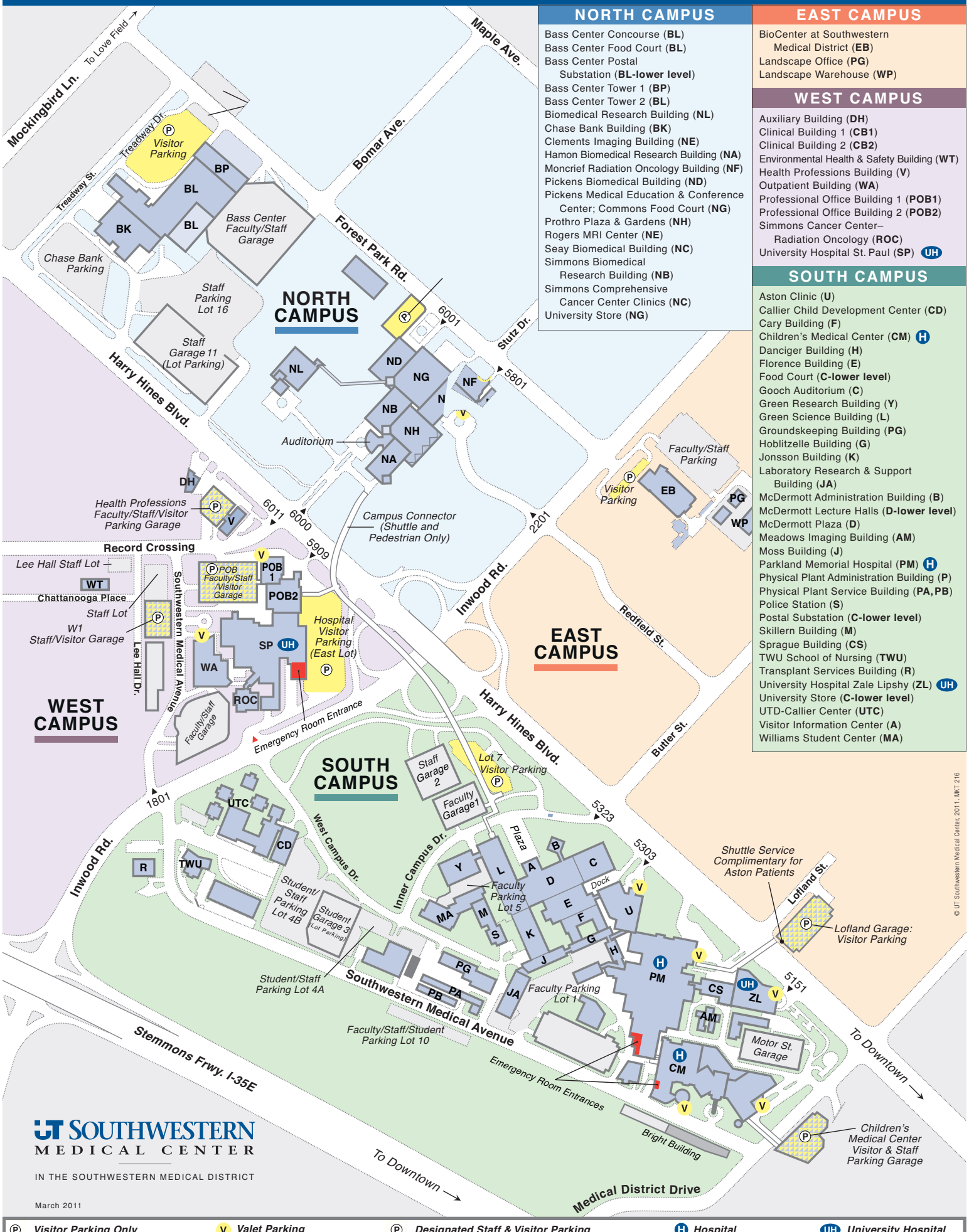
Out of Town Guests:

For our out of town guests, a patient representative is available to assist you in obtaining discounted hotel reservations. Please call **214-645-2393** for assistance.

Office Location:

Enclosed you will find a map with directions to our office. We are located on the fourth floor of Professional Office Building 2 at 5939 Harry Hines Blvd., Dallas, TX., 75390. This building is located at the intersection of Record Crossing and Harry Hines Blvd.

VISITOR GUIDE TO UT SOUTHWESTERN MEDICAL CENTER



Driving Directions: **The Professional Office Buildings 1 and 2** are located on the southwest corner of Harry Hines Blvd and Record Crossing Road. (POB2 is at 5939 Harry Hines Blvd, Dallas, TX 75390-9191)
See table below or call 214-648-6264.

From I-35E, traveling south (from Lewisville/Las Colinas - Take exit 432A for Inwood Road/ Southwestern Medical Center - Stay on service road to Inwood Road - Turn left at Inwood - Exit Harry Hines Boulevard northbound - The first traffic light is Record Crossing, turn left. - The Professional Office Bldgs are on the left. - Valet & garage parking are accessible from the first drive on the left.	**From I-35E, traveling North (from Duncanville/Lancaster)** - Take exit 432A for Inwood Road/ Southwestern Medical Center. - Stay on service road to Inwood Road - Turn right at Inwood - Exit Harry Hines Blvd northbound. - The first traffic light is Record Crossing, turn left - The Professional Office Bldgs are on the left. - Valet & garage parking are accessible from the first drive on the left.	**From US 75/Central Expressway** - Take exit 1A to merge onto TX366 W/Woodall Rodgers Freeway following signs to I-35E North to Denton - Take Exit 432A for Inwood Road/Southwestern Medical Center - Stay on service road to Inwood Road - Turn right at Inwood - Exit Harry Hines Boulevard northbound - The first traffic light is Record Crossing – turn left - The Professional Office Bldgs are on the left. - Valet & garage parking are accessible from the first drive on the left.
From Dallas North Toll way - Take Mockingbird exit - Bear right to Mockingbird intersection - Turn right at Mockingbird - Follow Mockingbird to Inwood Road - Turn left at Inwood - Exit Harry Hines Blvd northbound - The first traffic light is Record Crossing, turn left. - The Professional Office Bldgs are on the left. - Valet & garage parking are accessible from the first drive on the left.	**From Garland/Mesquite Area** - Take I-30 W - Take exit 44A to merge onto I-35E North - Take exit 432A for Inwood Road/ Southwestern Medical Center. - Stay on service road to Inwood Road - Turn right at Inwood - Exit Harry Hines Blvd northbound. - The first traffic light is Record Crossing, turn left. - The Professional Office Bldgs are on the left. - Valet & garage parking are accessible from the first drive on the left.	**From Fort Worth/Arlington Area** - Take I-30 E/Tom Landry Highway - Take exit 45 A on left to merge onto I-35E North toward Denton - Take exit 432A for Inwood Road/ Southwestern Medical Center. - Stay on service road to Inwood Road. - Turn right at Inwood. - Exit Harry Hines Blvd northbound -T he first traffic light is Record Crossing, turn left. - The Professional Office Bldgs are on the left. - Valet & garage parking are accessible from the first drive on the left.
From Dallas/Fort Worth International Airport (DFW - Go out South exit and continue south on International Pkwy S/ TX97 Spur S (Portions Toll) - Merge onto TX183 E toward Dallas/Irving - TX183 E becomes I-35E South - Take exit 432A for Inwood Road/ Southwestern Medical Center - Stay on service road to Inwood Road. - Turn Left at Inwood - Exit Harry Hines Blvd northbound - The first traffic light is Record Crossing, turn left. - The Professional Office Bldgs are on the left. - Valet & garage parking are accessible from the first drive on the left.	**From Dallas Love Field Airport** - Go southeast on Cedar Springs out of Love Field to Inwood Road - Turn right at Inwood - Exit Harry Hines Blvd northbound - The first traffic light is Record Crossing, turn left. - The Professional Office Bldgs are on the left. - Valet & garage parking are accessible from the first drive on the left.	**Upon Entering ask at Information Desk for Dermatology Clinics POB2 – 4th Floor** Cosmetic: 214-645-8989 General: 214-645-2400 Surgical: 214-645-8950

UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Department of Dermatology

New Patient Medical Information Sheet

Pt. Name:_____
Address:_____
_____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX-____ ____ ____ ____ SEX:_____
DOS: _____

DERMATOLOGY

Date:_____ Age_____

How were you referred to our clinic?

Physician (full name): Dr._____

Did the requesting physician see you for your skin condition? ◯ No ◯ Yes

Friend (name):_____ Other (please specify):_____

Pharmacy Name:_____ Phone: _____

Medical history: In your own words, please state the reason for your visit **(chief complaint)**:_____

_____

_____

How long have you had this problem? **(duration)**_____

What parts of your body are affected? **(location)**_____

What makes it better? What makes it worse? **(change in severity)**_____

_____

How does this problem bother you? **(symptoms)**_____

What treatments have you received for this problem? **(previous therapy)**_____

_____

_____

Is your problem ◯ worsening? ◯ stable? ◯ improving? **(timing)** Explain:_____

_____

Past medical/family/social history: Please list all past major illnesses and operations:_____

_____

_____

Please list all medications you are currently taking:_____

_____

_____

Please list all drug and environmental allergies:_____

_____

Is there a family history of a condition similar to yours? ◯ No ◯ Yes Additional information:_____

_____

Is there a family history of (please mark the circle(s) that apply): ◯ adult acne ◯ asthma ◯ diabetes ◯ eczema ◯ hay fever ◯ genetic diseases ◯ hair loss ◯ melanoma ◯ psoriasis ◯ skin cancer Additional information:_____

Occupation:_____

Do you smoke? ◯ No ◯ Yes Do you drink alcohol? ◯ No ◯ Yes

Form # DRA/NPMIS-004 / 05.05 (Rev. 08.06)

UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Department of Dermatology

New Patient Medical Information Sheet

Pt. Name:_____

Address:_____

_____

City State Zip

MRN: _____

DOB: _____

SSN: XXX-XX-___ ___ ___ ___ SEX:_____

DOS: _____

Review of Systems:

Skin: Have you seen a doctor for other skin problems? ◯ No ◯ Yes Which ones?_____

_____

Do you have (please mark circle(s) that apply): ◯ hair loss ◯ skin cancer ◯ abnormal moles?

When you are exposed to sunlight, do you:

1) ◯ Always burn
2) ◯ Usually burn, rarely tan
3) ◯ Often burn, tan slowly
4) ◯ Sometimes burn, tan well
5) ◯ Rarely burn, always tan
6) ◯ Never burn, deeply tan

Women: Are you pregnant? ◯ No ◯ Yes Do you plan to become pregnant soon? ◯ No ◯ Yes

Are you nursing? ◯ No ◯ Yes

Do you have any breast problems? ◯ No ◯ Yes Explain:_____

Mark circle next to any symptom or condition you are having.

General
- ◯ fever
- ◯ chills
- ◯ weight loss
- ◯ loss of appetite
- ◯ fatigue

Head, Eyes, Ears, Nose, Throat
- ◯ visual problems
- ◯ dry eyes
- ◯ eye disease
- ◯ ringing in ears
- ◯ ear disease
- ◯ bloody nose
- ◯ stuffy nose
- ◯ swallowing difficulties
- ◯ dry mouth
- ◯ sore mouth
- ◯ mouth ulcers

Cardiovascular
- ◯ pacemaker
- ◯ heart disease
- ◯ mitral valve prolapse
- ◯ hypertension
- ◯ chest pain

Respiratory
- ◯ cough
- ◯ difficulty breathing
- ◯ lung disease
- ◯ tuberculosis
- ◯ coughing up blood

Gastrointestinal
- ◯ liver disease
- ◯ intestinal disease
- ◯ heartburn/indigestion
- ◯ abdominal/stomach pain
- ◯ diarrhea
- ◯ constipation
- ◯ blood in stool or black stool
- ◯ rectal pain
- ◯ nausea
- ◯ vomiting

Genitourinary
- ◯ kidney disease
- ◯ bladder disease
- ◯ blood in urine/dark urine
- ◯ female problems
- ◯ stillbirth/spontaneous abortion
- ◯ problems with urination

Musculoskeletal
- ◯ joint aches
- ◯ swollen joints
- ◯ muscle aches
- ◯ muscle weakness
- ◯ back pain
- ◯ ankle swelling
- ◯ fingers sensitive to cold

Neurologic
- ◯ epilepsy/seizures
- ◯ headaches
- ◯ stroke
- ◯ dizziness
- ◯ disorientation
- ◯ confusion
- ◯ memory loss
- ◯ numbness
- ◯ double vision
- ◯ loss of consciousness

Psychiatric
- ◯ nervous breakdown
- ◯ depression
- ◯ insomnia

Endocrine
- ◯ diabetes
- ◯ enlarged glands
- ◯ hormonal problems
- ◯ thyroid disease

Hematologic/Lymphatic
- ◯ anemia
- ◯ free bleeding tendency

Immunologic
- ◯ immune deficiency
- ◯ frequent infections

If needed, please elaborate on any of the above:_____

_____

Thank you very much for your cooperation!

_____

Patient's Signature

I have read and reviewed this form with the patient.

Physician's signature_____, M.D.

Form # DRA/NPMIS-004 / 05.05 (Rev. 08.06)

UT SOUTHWESTERN
MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS
University Clinics

Patient's Request for Release of Information: Authorization for Verbal Release of Protected Health Information to Designated Persons

Pt. Name: _____
Address: _____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX- _____ Sex: _____
DOS: _____

AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO UT SOUTHWESTERN MEDICAL CENTER TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSONS, DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES. THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.

I AUTHORIZE UT Southwestern Medical Center to communicate my health information to the person(s) listed below ("Designated Persons") for the following purposes: to orally confirm my appointments; to discuss results of my X-ray, laboratory or other test results; to pick up sample medications or written prescriptions for me; to discuss my health care, diagnosis, prognosis, and treatment plans; and to discuss billing and payment for medical services provided by UT Southwestern Medical Center.

Please print the following information for each Designated Person:

Name:_____ Relationship to the patient:_____

Address:_____ Telephone:_____

_____ Alternate Telephone:_____

_____

Name:_____ Relationship to the patient:_____

Address:_____ Telephone:_____

_____ Alternate Telephone:_____

_____

I UNDERSTAND that this authorization applies to all departments, healthcare providers and/or employees at UT Southwestern Medical Center.

I UNDERSTAND that this authorization is voluntary.

I UNDERSTAND that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

I UNDERSTAND that this authorization will be effective for my lifetime, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time by sending a written statement of revocation to:

UT Southwestern Medical Center
Release of Information Department
5323 Harry Hines Blvd.
Dallas, TX, 75390-8864

If I revoke the authorization, it will not have any effect on any actions taken by UT Southwestern Medical Center prior to the processing of the revocation.

I UNDERSTAND that my refusal to sign this authorization will not negatively affect my health care services at UT Southwestern Medical Center.

Form # FMA/PRROIAVRPHIDP-001 / 11.03 (Rev. 10.05) Original – Health Information Management Department Copy – Patient

COMPLIANCE

UT SOUTHWESTERN
MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS
University Clinics

Patient's Request for Release of Information: Authorization for Verbal Release of Protected Health Information to Designated Persons

Pt. Name:
Address:
City State Zip
MRN:
DOB:
SSN: XXX-XX- SEX:
DOS:

BY SIGNING THIS AUTHORIZATION I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS CONTAINED HEREIN. I UNDERSTAND THAT UT SOUTHWESTERN MEDICAL CENTER WILL PROVIDE ME WITH A COPY OF THIS SIGNED AUTHORIZATION FORM.

PATIENT:
Print name:_____

Signature:_____

Date:_____

IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:
Print Name of Patient:_____
Print Name of Legal Representative:_____
Relationship to Patient:_____
By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative*.
Signature of Legal Representative:_____
Date:_____

**Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*

Revocation of Authorization

This section is to be completed ONLY in the event the patient seeks to revoke the above authorization after signature.
By my signature below, I am revoking this authorization. I understand that this revocation will be effective when received by UT Southwestern Medical Center and will not be effective to the extent that UT Southwestern Medical Center has relied on my authorization prior to receiving notice of my revocation.

The designated person(s) to be revoked:_____
PATIENT:_____
Print name:_____
Signature:_____
Date:_____

IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:
Print Name of Patient:_____
Print Name of Legal Representative:_____
Relationship to Patient:_____
By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative*:
Signature of Legal Representative:_____
Date:_____
**Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*

This Section for Internal Use Only

Date revocation received:_____ Date revocation processed:_____

Name of employee processing request:_____

Form # FMA/PRROIAVRPHIDP-001 / 11.03 (Rev. 10.05) Original – Health Information Management Department Copy – Patient