

Patient Information Form

Name: _____
(First) (Last)

Date of Birth: ___/___/____ GENDER: M F Marital Status: _____

SSN #: _____ - _____ - _____

Address: _____ Suite / Apt: _____

City: _____ State: ___ Zip Code: _____

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Mobile Phone: (____) _____ - _____

E-Mail: _____

Preferred Contact Method (Circle one): HOME MOBILE WORK

Insurance Policy Holder:

Name: _____ DOB: ___/___/____
(First) (Last)

Relationship: _____

Medical History Form

Patient Name: _____ **Date of Birth:** __/__/____

Reason for Visit and Location of Problem: _____

Past Medical History: (Check all that apply. If NONE, please check NONE)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Lumpectomy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lupus/ Rheumatoid Arthritis |
| <input type="checkbox"/> Bleeding Disorder (or bleeding issue) | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Transplant | Hyper or Hypo (Circle one) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Fever Blister | | <input type="checkbox"/> NONE |

Do you have a history of Skin Cancer or Skin Disorders?

(Examples: acne, actinic keratosis, basal cell, eczema, melanoma, psoriasis, squamous cell)

Yes ___ No ___ If yes, please indicate condition or disorder: _____

Family History of Melanoma? (circle one) **Yes** Relation: _____ **No**

Medications: _____

(Enter all current medications including non-prescription and birth control: if none mark N/A)

Allergies: _____

(Please enter all allergies including allergy to medications; if none mark N/A)

Review of Symptoms: (Check all that apply. If NONE, please check NONE)

- | | |
|---|--|
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Unintentional weight loss |
| <input type="checkbox"/> Problems with scarring/keloids | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Fever or Chills | |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> NONE |

Alerts: (Check all that apply. If NONE, please check NONE)

- | | |
|--|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to Topical Antibiotics | <input type="checkbox"/> Require antibiotics prior to surgical procedure |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Rapid heartbeat with Epinephrine |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Are you pregnant or currently trying to get pregnant? Notify physician verbally | |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> NONE |

Preferred Pharmacy Name: _____ **Telephone:** (____) ____ - _____

Address (or cross street): _____ **City:** _____

Patient Intake Form

This is a requirement by the government center for medical services based on the merit-based payment system.

Date: __/__/____

Print Name: _____

Are you a smoker? **Current** **Former** **Never**

Do you consume Alcohol? **Yes** **No** **Occasional**

Did you have a flu vaccine this year? **Yes** **No**

Have you ever had a pneumonia vaccine? **Yes** **No**

Do you have a living will? **Yes** **No**

Do you have an Advanced Directive / Power of Attorney? **Yes** **No**

Definition: a legal document expressing a persons wishes about critical care when he is unable to decide for himself.

*Name: _____

*Relationship: _____

*Phone Number: (___) ___ - ____

Referring Physician / Primary Care Physician: _____

Signature: _____

Please initial on each line that you have read and understand each statement;

_____ *I hereby authorize the release of any information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or for that portion not covered by my insurance. I further understand that if there is any delay or dispute regarding my insurance, I will be responsible for payment on my account within a reasonable period of time. I understand that I will be responsible for 100% of all cosmetic charges incurred in this office, regardless of any provider discount through my insurance carrier. I understand that it is my responsibility to obtain all necessary referrals from my PCP. If services are denied due to lack of referral, I am responsible for payment in full.

_____ *I understand that Specialist in Dermatology and Cosmetic Medicine has adopted strict Privacy Practices in Compliance with HIPAA regulations. Specialist in Dermatology and Cosmetic Medicine reserves the right to change its practice to maintain compliance with privacy regulations. More complete review of their privacy practices are available upon request. In the event of an emergency, Specialist in Dermatology and Cosmetic Medicine will disclose information related to your emergency condition.

NO SHOW FEE

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Specialist In Dermatology & Cosmetic Medicine sends text message and or e-mail reminders in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us at least 24 hour in advance so we may reschedule you, and accommodate those patients who are waiting for an appointment.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a \$50.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly.

I understand the "no-show" policy of Specialist In Dermatology & Cosmetic Medicine and agree I will be charged \$50.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

Signature _____

Date _____