SPECIALISTS IN DERMATOLOGY & COSMETIC MEDICINE

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: _________________

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Medical History Form

Reason for Visit and Location of Problem: ____

Height:____________ **Weight:**__________

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

__ Allergies (Seasonal)
__ Asthma
__ Bleeding Disorder (or bleeding issue)
__ Cancer: ________________________
__ Coronary Artery Bypass
__ Depression
__ Diabetes
__ Fever Blister
__ Heart Valve Replacement
__ High Blood Pressure
__ High Cholesterol
__ HIV/AIDS
__ Joint Replacement
__ Kidney Transplant
__ Liver Disease
__ Lumpectomy
__ Lupus/ Rheumatoid Arthritis
__ Mastectomy
__ Organ Transplant
__ Thyroid Disease
Hyper or Hypo (Circle one)

__ 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)

__ Problems with bleeding
__ Problems with healing
__ Problems with scarring/keloids
__ Fever or Chills
__ Other: _____________________
__ Night Sweats
__ Unintentional weight loss
__ Joint Pain

__ NONE

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

__ Allergy to Adhesive
__ Allergy to Lidocaine
__ Allergy to Topical Antibiotics
__ Artificial Heart Valve
__ Blood Thinners
__ MRSA
__ Pacemaker
__ Require antibiotics prior to surgical procedure
__ Rapid heartbeat with Epinephrine
__ Defibrillator
__ Are you pregnant or currently trying to get pregnant? Notify physician verbally
__ Breastfeeding

__ NONE

Preferred Pharmacy Name: ___________________________________ **Telephone: (_ _ _) _ _ _ - _ _ _ _**

Address (or cross street): _____________________________________ **City:** _________________________

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DERMATOLOGY &
COSMETIC MEDICINE

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 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 __________________________________