

Welcome!

DERMATOLOGY & CLINICAL SKIN CARE CENTER and ROCKLEDGE SURGERY CENTER INC
PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ SEX: M F AGE: _____
(First) (M) (Last)

BIRTHDATE: _____ PATIENT SS#: _____

HOME ADDRESS: _____
(Street)

(City) (State) (Zip)

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

PREFERRED # TO CALL REGARDING LABS/APPOINTMENTS/RESULTS: _____

MAY WE LEAVE A MESSAGE IF UNABLE TO REACH YOU? (MAY CONTAIN PERSONAL INFO): _____ YES _____ NO

EMAIL: _____

MAY WE EMAIL YOU PERIODICALLY WITH UPDATES AND NEWS ON THE PRACTICE? _____ YES _____ NO

EMPLOYER: _____ OCCUPATION: _____

SPOUSE (or Parent) NAME: _____ WORK PHONE: _____

SPOUSE (or Parent) EMPLOYER: _____

HOW DID YOU HEAR ABOUT US (PLEASE CHECK)?

Friend/Family ___ Referring Physician ___ Insurance Plan ___ Our Website ___ Internet Search/Other Website ___

Yellow Pages ___ Bethesda Magazine ___ Gazette Newspaper ___ Other (Please specify): _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: _____

INSURANCE INFORMATION PRIMARY INSURANCE SECONDARY INSURANCE

INSURANCE CO. NAME: _____

I.D. #: (if not on card) _____

NAME OF POLICYHOLDER: Check if policy holder is patient _____ Check if policy holder is patient _____

POLICYHOLDER'S DOB: _____

POLICYHOLDER'S SS#: _____

RELATIONSHIP TO PATIENT: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (SELF, SPOUSE, PARENT OR LEGAL GUARDIAN)

NAME: _____ SS#: _____ BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____ BILLING ADDRESS: _____
(Street)

(City) (State) (Zip)

HOME PHONE #: _____ WORK #: _____ CELL #: _____

OVER PLEASE *OVER PLEASE*** OVER PLEASE*** OVER PLEASE ***OVER PLEASE**

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE #: _____ WORK #: _____ CELL #: _____

Assignment of Benefits: I hereby authorize the physicians and staff of Dermatology & Clinical Skin Care Center *and* Rockledge Surgical Center to render treatment to me/my dependents. I further authorize Dermatology & Clinical Skin Care Center *and* Rockledge Surgery Center to release my personal health information for purposes of treatment, payment or operations by phone, mail or fax. I assign and authorize payment of medical/surgical benefits directly to Dermatology & Clinical Skin Care Center *and* Rockledge Surgery Center, Inc.

Financial Policies: I understand that any unpaid balances or non-covered services will be my responsibility. I understand that if I provide incorrect or expired insurance information I will assume full financial responsibility for all charges incurred. I understand I will be charged a missed appointment fee of \$25.00 per visit should I fail to provide 24 hours notice of cancellation or rescheduling. I understand that if my copay is not paid at the time of service, I will be charged a \$10 billing fee. I also understand I will be charged a \$30.00 collections fee should my account be referred to a collections company for non-payment and a \$35.00 fee for any and all returned checks. We accept cash, checks, MasterCard, Visa and American Express as forms of payment.

By my signature, I certify that the information I have reported with regard to my insurance coverage is correct and acknowledge that I have read and understand the above financial policies (if patient is a minor, signature of responsible party):

SIGNATURE: _____ DATE: _____

Initial _____ Date _____
Initial _____ Date _____

Initial _____ Date _____
Initial _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I authorize the employees of Dermatology & Clinical Skin Care Center and Rockledge Surgery Center and other contracted entities to view this information and to use this information to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Authorize third party to verify insurance benefits and eligibility.

I have been offered a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Signature: _____

Relationship to patient _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Patient History Intake Form

Name _____ Age _____ DOB _____

Are you pregnant at this time? Yes No Are you nursing at this time? Yes No

Do you have an **allergy** to any medications? No Yes (List): _____

Please fill out sections 1-5 as completely as possible.

1.) Main reason for today's visit:	
Where is it located?	
How long has it been present?	
Severity/How bad is it? Please circle:	Mild Moderate Severe 1 2 3 4 5
Have you ever had a similar problem in the past and when?	
What other signs and symptoms are you experiencing? Please circle: Bleeding Growing Sore Itching Burning Changing Other (please describe):	
What have you used that makes it better/worse? (Medicines or over-the-counter products)	
2.) What medications (Including topical), over-the-counter medicines, or vitamins are you taking? None List:	
3.) Family History: check the box if your blood-relative family members have had:	
skin cancer (other than melanoma)	eczema/hay fever/asthma psoriasis baldness/hair loss/thinning hair
abnormal moles/large number of moles	melanoma lupus/rheumatoid arthritis diabetes or thyroid problems
4.) Social History: Ethnicity/Race/Ancestry _____ Occupation _____ Tobacco Use? Frequency? _____ Lifetime # of peeling sunburns _____ Tanning bed use (how often)? _____ Alcohol use (amt per day)? _____	

5.) Personal medical history: Do you currently or have you in the past had any of these medical conditions?

Abnormal moles	Cancer
<input type="checkbox"/> Any new or changing moles or lesions	Bleeding problems, aspirin or blood thinner, history of blood transfusion
Actinic keratoses (precancers)	Constitutional symptoms (fatigue, weight loss, fever, nausea, vomiting)
Eczema/Atopic Dermatitis	Endocrine disease (diabetes, thyroid, or other hormone problems)
Hair disorders	Eye, mouth, esophagus, stomach, bowel problems
Keloid or abnormal scarring	Frequent infections, immunocompromised from organ transplant
Melanoma	Hay fever or seasonal allergies or allergies to food, insects, or other materials
Nail disorders	Heart disease (high blood pressure, high cholesterol, valve problems, pacemaker)
Prior surgery	HIV/AIDS (CD4 count _____ : Viral load _____)
Psoriasis	Kidney or urinary problems
Seborrheic dermatitis (dandruff)	Liver problems or hepatitis
Skin Cancer (not melanoma)	Neurologic disease (headache, seizure, stroke, nerve problems, or ear problems)
Other skin conditions	Rheumatologic disease (arthritis, muscle soreness, or Lupus)
	Sinus or lung disease (asthma, emphysema/COPD)

I understand the information above is an important part of my medical care and I have answered all of the above questions truthfully and to the best of my abilities.

Patient or Guardian sign here X _____ Date: _____

OFFICE USE ONLY: Initial History Physician Signature Grid Interval History

Patient ROS and PFS History was reviewed and unchanged, unless otherwise documented

Date Reviewed	Provider Signature	Date Reviewed	Provider Signature	Date Reviewed	Provider Signature
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Cosmetic Procedures Questionnaire

(Completion is Optional)

Welcome to the Dermatology & Clinical Skin Care Center

Name: _____ Date: _____

Phone: _____ E-Mail: _____

To help us better assess a treatment and product regime for you, please indicate what your concerns or interests are:

- | | |
|---------------------------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> <i>Wrinkles</i> | <input type="checkbox"/> <i>Sun Damage</i> |
| <input type="checkbox"/> <i>Brown Spots (requires medical evaluation)</i> | <input type="checkbox"/> <i>Scars</i> |
| <input type="checkbox"/> <i>Spider Veins</i> | <input type="checkbox"/> <i>Stretch Marks</i> |
| <input type="checkbox"/> <i>Cellulite</i> | <input type="checkbox"/> <i>Red Face</i> |
| <input type="checkbox"/> <i>Hair Removal</i> | <input type="checkbox"/> <i>Acne Scarring</i> |
| <input type="checkbox"/> <i>Loose, Sagging Skin</i> | <input type="checkbox"/> <i>Other</i> _____ |
| <input type="checkbox"/> <i>Age Spots</i> | |

Would you like to receive information about any of the following in-office services? Please check all that apply:

- | | |
|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <i>Thermage Non-Surgical Facelift procedure</i> | <input type="checkbox"/> <i>Botox therapy for frown lines, crow's feet & forehead lines</i> |
| <input type="checkbox"/> <i>Fraxel Laser for facial rejuvenation</i> | <input type="checkbox"/> <i>Vbeam Laser for red complexions</i> |
| <input type="checkbox"/> <i>Fillers (Restylane, Radiesse, Juvederm, Sculptra, and Collagen for wrinkles</i> | <input type="checkbox"/> <i>Cool Touch Laser for facial wrinkles around eyes & mouth, acne scars</i> |
| <input type="checkbox"/> <i>Gentle Waves for collagen stimulation</i> | <input type="checkbox"/> <i>Clearlight Acne Treatments is a new light based treatment</i> |
| <input type="checkbox"/> <i>Diolite Laser for sun spots, freckles, blood vessels, and some birthmarks</i> | <input type="checkbox"/> <i>Photo Rejuvenation is designed to produce younger healthier looking skin through light therapy</i> |
| <input type="checkbox"/> <i>Sclerotherapy for the treatment of leg veins</i> | <input type="checkbox"/> <i>Microdermabrasion for wrinkles, skin pigmentation, scars, and stretch marks.</i> |
| <input type="checkbox"/> <i>Chemical Peels for wrinkles, skin pigmentation, scars, and acne</i> | <input type="checkbox"/> <i>Plastic Surgery – specify procedure or area: _____</i> |
| <input type="checkbox"/> <i>Liposuction using the tumescent technique to optimize results and safety</i> | <input type="checkbox"/> <i>Hair Removal using laser pulsed light therapy</i> |
| <input type="checkbox"/> <i>Esthetician Services / Spa Treatments such as Cellulite treatments and customized facials</i> | <input type="checkbox"/> <i>Other Services – please specify: _____</i> |