

Patient Information

Name _____ Date of Birth _____ Age _____
Billing Address _____
City _____ State _____ Zip Code _____ Marital Status _____
Sex _____ SS # _____ Email Address _____
Home Phone _____ Work Phone _____ Cell _____
Employer _____ Address _____

Emergency Contact Information
Parent / Guardian / Spouse

Name _____
SS# _____ **Birth Date** _____
Mailing Address _____

Home Phone _____
Work Phone _____
Employer _____
Address _____

Insured Member or Person Responsible for Payment

Same as Parent / Guardian / Self
Name _____
Address _____

Home Phone _____
Alternative # _____
Employer _____
Address _____
Date of Birth _____

I authorize the release of medical information necessary to process all claims & payment of medical benefits to the physician. In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. **Payment is required for all services at the time they are rendered.** In the event of any major procedures our office will file with the appropriate insurance. **However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments.** Cash, checks and all major credit cards are acceptable forms of payment, however if a check is returned for any reason you will be charged a returned check fee of \$70.00 minimum. **Your signature below signifies your understanding and willingness to comply with these policies.**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or going to www.LovelySkin.com/privacy.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. We provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

Photographs may be taken to display your condition to fellow dermatologists for research, diagnostic reasons or for our electronic records. No personal data will accompany any photograph taken if sent out for diagnostic purposes. Images are property of Skin Specialists, P.C.

I authorize Skin Specialists, P.C. to send me promotional materials from Advanced Skin Research and LovelySkin, Inc.

I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Skin Specialists has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Skin Specialists reserves the right to change the Notice of Privacy Practices
- I have the right to restrict the uses of my information but Skin Specialists does not have to agree to those restrictions
- I may revoke this Consent in writing at any time and all future disclosures will then cease
- Skin Specialists may condition receipt of treatment upon the execution of this Consent.

_____ **I am aware of the 48 hour notice for any changes or cancellations to my appointment.** I am aware that if my appointment is changed or cancelled more than twice without 48 hours notice, I will be charged the price of the service.

This Consent was signed by:

Printed Name – Patient or Representative
Relationship to Patient _____ / _____ / _____
(If other than patient) Signature Date
Witness _____ / _____ / _____
Signature of Skin Specialists, P.C employee Date

REFERRAL SURVEY

(Please choose the one answer which is most appropriate)

- ___ RECOMMENDED BY A **FRIEND OR RELATIVE**
NAME OF PERSON _____
- ___ **INSURANCE BOOKLET**
- ___ **REFERRED** BY MY PHYSICIAN
PHYSICIAN'S NAME _____
- ___ RECEIVED **FLYER** IN MAIL
- ___ SAW **SIGN** ON BUILDING
- ___ **NEWSPAPER AD**
NAME OF NEWSPAPER _____
- ___ **BILLBOARD**
WHERE _____
- ___ **TELEVISION**
WHICH STATION _____
- ___ **RADIO AD**
WHICH STATION _____
- ___ **INTERNET**
- ___ **YELLOW PAGES**
- ___ **OTHER**
PLEASE SPECIFY: _____

MEDICAL QUESTIONS

ALLERGIC TO ANY MEDICATIONS? _____ NO _____ YES

IF YES, PLEASE LIST THEM: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

DO YOU NEED TO TAKE ANTIBIOTICS BEFORE DENTAL OR SURGICAL PROCEDURES, OR HAVE A HISTORY OF RHEUMATIC FEVER, RHEUMATIC HEART DISEASE, OR HEART VALVE PROBLEMS? _____ NO _____ YES

DO YOU HAVE A BLEEDING DISORDER, BLEED ABNORMALLY AFTER SURGERY, OR TAKE MEDICINE THAT THINS YOUR BLOOD; SUCH AS ASPIRIN: _____ NO _____ YES

LIST PREVIOUS HOSPITALIZATIONS/SURGERIES:

LIST MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY:

PLEASE LIST YOUR PERSONAL PHYSICIAN:

NAME: _____

ADDRESS: _____

NAME: _____ DATE: _____

REASON FOR VISIT _____

Do you have any problems with the following body functions? (If yes, please explain.)

- NO YES IF FEMALE, ARE YOU PREGNANT?
DATE DUE: _____
- NO YES GENITALIA: _____ LAST MENSES: _____
- NO YES NEUROLOGICAL/PSYCHIATRIC: _____
- NO YES LIVER, KIDNEY OR URINARY: _____
- NO YES STOMACH OR BOWELS: _____
- NO YES EYES, EARS, NOSE, OR THROAT: _____
- NO YES MUSCLES OR JOINTS: _____
- NO YES HEART OR LUNGS: _____
- NO YES THYROID: _____
- NO YES SKIN: _____

Have you had any of the following conditions?

- NO YES BLOOD TRANSFUSION? PLEASE EXPLAIN
CIRCUMSTANCES: _____
- NO YES KELOID OR LARGE SCARS/POOR SCARS
- NO YES DIFFICULTY WITH ANESTHESIA?
EXPLAIN: _____
- NO YES HISTORY OF MELANOMA OR SKIN CANCER
- NO YES RADIATION TREATMENT FOR TUMORS
- NO YES ALLERGIES TO EGGS OR SOYBEANS
- NO YES COLD SORES OR FEVER BLISTERS
- NO YES MALIGNANT HYPERTHERMIA
- NO YES PREVIOUS ACCUTANE USE
- NO YES HISTORY OF BLOOD CLOTS?
- NO YES HIGH BLOOD PRESSURE
- NO YES CANCER OR LEUKEMIA
- NO YES HEPATITIS OR HIV
- NO YES DIABETES
- NO YES SEIZURES
- NO YES ALCOHOL USE? HOW MUCH? _____
- NO YES DO YOU SMOKE? HOW MUCH? _____