

Patient Information

Name _____ Date of Birth _____ Age _____
Billing Address _____
City _____ State _____ Zip Code _____
Marital Status _____ Sex _____ SS # _____
Referred By _____ Do you want a letter sent to your referring doctor? Yes _____ No _____
Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____
Employer _____ Address _____

_____ **YES!** I would like an appointment confirmation via email. Email address _____

**Parent / Guardian / Spouse /
Emergency Contact Information**

Name _____
SS# _____ Birth Date _____
Mailing Address _____

Home Phone (____) _____
Work Phone (____) _____
Employer _____
Address _____

Person Responsible for Payment :

Same as Parent / Guardian / Self

Name _____
Address _____

Home Phone (____) _____
Alternative No. (____) _____
Employer _____
Address _____
Date of Birth _____

I authorize the release of medical information necessary to process all claims and also authorize 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. Your signature below signifies your understanding and willingness to comply with this policy.

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.

Drivers License will be scanned and kept on file due to the requirements of the Red Flag Identity Theft Prevention Program effective May 1, 09.

Photographs may be taken to display your condition to fellow dermatologists for research or diagnostic reasons. No personal data will accompany any photograph taken.

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.

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)

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.

This Consent was signed by:

Relationship to Patient
(If other than patient)

Witness

Printed Name – Patient or Representative

Signature

Signature of Skin Specialists, P.C employee

_____/_____/_____
Date

_____/_____/_____
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

ALLERGIES TO ANY MEDICATIONS? _____ YES _____ NO

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? _____ YES _____ NO

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.)

IF FEMALE, ARE YOU PREGNANT? _____ YES _____ NO

DATE DUE: _____

GENITALIA: _____ LAST MENSES: _____

NEUROLOGICAL/PSYCHIATRIC: _____

LIVER, KIDNEY OR URINARY: _____

STOMACH OR BOWELS: _____

EYES, EARS, NOSE, OR THROAT: _____

MUSCLES OR JOINTS: _____

HEART OR LUNGS: _____

THYROID: _____

SKIN: _____

Have you had any of the following conditions?

BLOOD TRANSFUSION? PLEASE EXPLAIN

CIRCUMSTANCES: _____

KELOID OR LARGE SCARS/POOR SCARS _____

DIFFICULTY WITH ANESTHESIA? _____

EXPLAIN: _____

HISTORY OF MELANOMA OR SKIN CANCER _____

RADIATION TREATMENT FOR TUMORS _____

ALLERGIES TO EGGS OR SOYBEANS _____

COLD SORES OR FEVER BLISTERS _____

MALIGNANT HYPERTHERMIA _____

PREVIOUS ACCUTANE USE _____

HISTORY OF BLOOD CLOTS? _____

HIGH BLOOD PRESSURE _____

CANCER OR LEUKEMIA _____

HEPATITIS OR HIV _____

DIABETES _____

SEIZURES _____

ALCOHOL USE? HOW MUCH? _____

DO YOU SMOKE? HOW MUCH? _____