

TODAY'S DATE: _____

PATIENT INFORMATION

PATIENT NUMBER:

FULL LEGAL NAME		DOB	SS# (optional for Identification only)
PREFERRED LANGUAGE	SEX	RACE/ETHNICITY	
MAILING ADDRESS (Street, City, State, Zip)			
HOME PHONE	CELL PHONE	EMAIL	
May we leave messages? <input type="checkbox"/> Y <input type="checkbox"/> N	May we leave messages? <input type="checkbox"/> Y <input type="checkbox"/> N		
MARITAL STATUS	SPOUSE NAME	SPOUSE PHONE	
EMPLOYER	EMPLOYER ADDRESS	WORK PHONE	
		May we leave messages? <input type="checkbox"/> Y <input type="checkbox"/> N	
EMERGENCY CONTACT NAME	PHONE	RELATIONSHIP	

GUARANTOR/FINANCIAL RESPONSIBILITY INFORMATION – If other than patient

NAME	DOB	RELATIONSHIP TO PATIENT
ADDRESS (Street, City, State, Zip)		

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	POLICY HOLDER'S NAME	DOB	RELATIONSHIP TO PATIENT
ID#	GROUP #	EFFECTIVE DATE	COPAY AMOUNT

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	POLICY HOLDER'S NAME	DOB	RELATIONSHIP TO PATIENT
ID#	GROUP #	EFFECTIVE DATE	COPAY AMOUNT

MEDICAL CONTACT/RELEASE OF INFO Is there anyone you would like to give us permission to speak to on your behalf?

NAME	RELATIONSHIP
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I authorize the release of medical information to my primary care or referring physicians if needed and as necessary to process insurance claims, insurance applications and prescriptions, whether by mail or by fax. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I authorize payment of medical benefits to be made directly to The Skin Wellness Center. I also understand that regardless of any insurance coverage I may have, I am responsible for any bills incurred and will be responsible for any charges associated with collecting this debt. I acknowledge that I have a right to request a copy of the Notice of Privacy Practices at any time.

Printed Name of Patient or Patient's Representative

Signature of Patient or Patient's Representative

Relation if Not Patient

Date

TODAY'S DATE: _____

PATIENT INFORMATION

PATIENT NUMBER: _____

FULL NAME		DOB
REASON FOR TODAY'S VISIT		
PRIMARY CARE PROVIDER	REFERRING PROVIDER	
PHARMACY NAME AND LOCATION	PHONE	
LIST ALL CURRENT MEDICATIONS, VITAMINS, HERBALS		
LIST ANY MEDICATION ALLERGIES		

PAST MEDICAL HISTORY Do you have now, or have you ever had (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Diabetes (circle one): Type 1 or 2 | <input type="checkbox"/> Hyperthyroid (high) |
| <input type="checkbox"/> Arthritis / Joint deformity | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypothyroid (low) |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy / Seizures / Convulsions | <input type="checkbox"/> Irregular Heartbeat / Heart murmur |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Bladder disease | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Lung cancer |
| <input type="checkbox"/> Bleeding disorder / Bleed easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Bowel disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Cervical cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Immunosuppressed |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Other not listed: _____ |

SKIN HEALTH (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> History of skin disease | What type? _____ |
| <input type="checkbox"/> History of MRSA infection | |
| <input type="checkbox"/> Skin cancer | What type(s)? <input type="checkbox"/> Basal Cell <input type="checkbox"/> Squamous Cell <input type="checkbox"/> Melanoma How long ago? _____ |
| <input type="checkbox"/> Family history of melanoma | What relation? _____ |
| <input type="checkbox"/> Tanning bed use | <input type="checkbox"/> Past use <input type="checkbox"/> Currently using How often? _____ |
| <input type="checkbox"/> Sunscreen use | <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently |
| <input type="checkbox"/> Reaction to local anesthesia | What type of reaction? _____ |
| <input type="checkbox"/> Current smoker | How much do you smoke? _____ |
| <input type="checkbox"/> Past smoker | |

How tall are you? ____ ft ____ in How much do you weigh? _____ lbs.

Are you pregnant or breast feeding? Yes No Date of last pap smear: _____

Do you use a cane, walker, wheelchair, or other mobility aid for walking or balance? Yes No

Have you fallen in the past 3 months? Yes No Do you feel unsteady or at risk for falls? Yes No

What is your occupation? _____

Printed Name of Patient or Patient's Representative

Signature of Patient or Patient's Representative

Relation if Not Patient

Date

Patient Name _____ Date _____ Patient # _____

Consent to Treat and Financial Policy

- I consent to treatment necessary for the care of the above-named patient.
- I authorize the release of all medical records necessary to the referring or treating physician(s) and to process insurance claims filed on my behalf or that of my dependents.
- I authorize and request that insurance payments be made directly to The Skin Wellness Center.
- I understand that if I do not have insurance at the time of service, I will be financially responsible for full payment of all services rendered.
- I understand that payment of copays, cosmetic treatment, and out of pocket charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- If this account becomes past due, I will be responsible for all reasonable collection service fees. If legal action is required to collect this account, I agree to pay all attorney fees and court costs.

Appointments

- Your appointment time was scheduled based on the reason you gave us when you scheduled your appointment. If you have additional problems or need to discuss additional concerns with your provider, we may have to schedule another appointment to address these problems/concerns.
- Please bring your insurance card and be prepared to present it at every appointment.
- We respectfully ask for 24 hours' notice if you will be unable to keep an appointment.
- I understand that not showing for a cosmetic appointment may result in a no-show fee or loss of deposit.
- Multiple no-shows or cancellations may result in discharge from the practice.

Late Arrivals

- Out of respect for other patients arriving on time, if you arrive late, with or without notice, you may be asked to reschedule.
- It is at the discretion of your care provider whether you can be worked back into the schedule. Being worked back into the schedule will result in a longer wait time. To be worked back into the schedule, you must remain in the office until that time.

Your Prescriptions

- Unless you request a written prescription to take with you after your visit, prescriptions are sent electronically to your pharmacy. We suggest you call your pharmacy to make sure your prescriptions are ready before going to pick them up.
- Insurance companies often change their list of "preferred drugs." We try to keep current with these changes. If your prescription is rejected by your insurance because it is not on their "preferred list," additional time will be required for approval of a substitute medication.
- Obtaining insurance authorization for a medication is a lengthy process and may take several days to weeks to process through insurance. The length of this process is dictated by your insurance provider. We respectfully request your patience when waiting for medication authorizations.

Lab

- We participate only with Dermatopathology Partners for all biopsy samples. Your insurance will be billed by Dermatopathology Partners, and you are responsible to Dermatopathology Partners for any balance due after insurance.

