

PATIENT INFORMATION

Must present picture ID and Insurance card to be seen.

Name: _____

Last First M.I. (Preferred Name)

Address: _____

Street City State Zip

Date of Birth: ____ / ____ / ____ Age: ____ Gender: M F Marital Status: S M D W

Ethnicity: _____ SSN: _____ Primary Contact Number: Home Cell Work

Home: (____) _____ Cell: (____) _____ Work: (____) _____ Ext: _____

Email: _____ Appointment reminders: Text Message or Email

You will receive an email from our patient portal FollowMyHealth to join, it will allow you to view office visits, lab & pathology reports, request, reschedule, or cancel an appointment, and send messages to our team.

Employer: _____ Occupation: _____

Pharmacy of choice: _____ Location: _____

In case of emergency, notify: _____ Phone: _____

Relationship

Who is your family doctor? _____ Phone: _____

INSURANCE SUBSCRIBER (Check if same as above)

Name: _____

Last First M.I. SS#

Address: _____

Street City State Zip

Work Phone: (____) _____ Ext. _____ Home Phone: (____) _____

Cell Phone: (____) _____ Date of birth: ____ / ____ / ____ Relationship to patient: _____

I hereby authorize Dr. Street or her assistants to treat my child in my absence. _____

Parent Signature

INSURANCE INFORMATION (Please present card at time of check-in.)

Primary Insurance name: _____ **Secondary** Insurance name: _____

Policy holder: _____ Policy Holder: _____

Contract #: _____ Contract #: _____

Group #: _____ Group #: _____

Relationship to patient: _____ Relationship to patient: _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this provider for any services furnished me by this physician. I authorize any medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine benefits for related medical services. I authorize Medicare to furnish the above-named doctor any information regarding my medical claims under Title XVII of the Social Security Act.

Commercial Insurance

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the doctor indicated on the claim. I understand I am financially responsible for any balance not covered by insurance. I give consent for Dr. Street to communicate with my referring physician.

Patient or Guardian Signature: _____ **Date:** ____ / ____ / ____

The Health Insurance Portability and Accountability Act

Patient Information Release

Patient Name: _____ **D.O.B:** _____

I hereby give my permission to release medical information regarding myself to family, friends, physician, or others listed below:

Patient or Guardian Signature: _____ **Date:** _____

The following information will assist us in your care and in any communication with you while protecting your confidentiality.

Please circle "YES" or "NO" and fill in the necessary information. List only the phone # where you want to be notified.

I give my permission to:

YES NO Leave a MESSAGE to remind me of my appointment at my:
Home # _____ Cell # _____ Other # _____

YES NO Leave a MESSAGE requesting that you call our office back regarding medical information:
(lab reports, prescriptions, important medical updates)
Home # _____ Cell # _____ Other # _____

YES NO FAX LAB results or other information regarding my condition to my family doctor or a physician to whom Doctor's Approach is referring me to.

YES NO Electronically Bill, Fax, or Telephone information to and/or from my Insurance Company for payment purposes.

I acknowledge that I have received a copy of the Notice of Privacy Policies and consent to the use of my information as outlined in the Notice of Privacy Policies from Doctor's Approach Dermatology and Laser Center, PC.

Patient or Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

MEDICAL HISTORY

Name: _____ D.O.B: _____

Why are you here today and when did the problem begin? _____

Please list any previous skin conditions: _____

Have you had skin cancer? _____, what type(s) and where was it located? _____

Has anyone in your family had skin cancer? _____, their relationship to you and type(s) of skin cancer: _____

Please list any known reactions, sensitivities to foods or plants: _____

List any reactions or allergies to medications: _____

Please list all medications you take or apply regularly: _____

Please list all medications/drugs you have taken in the last two weeks including vitamins, drops, laxatives, suppositories, pills, aspirin, Tylenol, injections, marijuana, cocaine, tranquilizers, amphetamines, birth control pills, etc.: _____

Have you ever taken Accutane? _____ If yes, for how long? _____

Do you use: Tobacco _____ Caffeine _____ Alcohol _____ Recreational Drugs _____
_____ pks/day _____ cups/day _____ glasses/day type: _____

Do you have any artificial heart valves? Please explain: _____

Do you have any artificial joints? Location: _____ Year placed: _____

DO YOU HAVE A PACEMAKER OR OTHER TYPE OF IMPLANTED DEVICE TO REGULATE YOUR HEARTBEAT? _____ If yes, what type? _____

Do you have a mitral valve prolapse? _____

DO YOU NEED TO TAKE ANTIBIOTICS BEFORE ANY SURGERIES OR DENTAL PROCEDURES? IF SO WHAT _____

Please list your surgical history:

Surgery: _____ Year: _____ Surgery: _____ Year: _____
Surgery: _____ Year: _____ Surgery: _____ Year: _____
Surgery: _____ Year: _____ Surgery: _____ Year: _____

I consent to being tested for hepatitis/HIV(AIDS) if an office staff member is directly exposed to potentially contagious material (i.e., needle stick). Initials: _____ Date: _____

Patient Name: _____ D.O.B: _____ HEIGHT: _____ WEIGHT: _____

MEDICAL HISTORY--REVIEW OF SYSTEMS

Please circle all conditions that apply, please check NO if none of the conditions apply

System Review	Circle all that apply (Presently)	No	Comments/Other
Musculoskeletal	Arthritis, weakness, back pain, joint pain, cramps, stiffness, osteoporosis		
Neurologic	Seizures, stroke, balance changes, numbness/tingling, headaches, dizziness, migraines, myasthenia gravis		
Constitutional	Fevers, night sweats, chills		
Eyes	Visual loss or change, trauma, contacts, cataracts, blurred vision, glaucoma		
Ears, Nose, Throat	Loss of hearing, trouble swallowing, nosebleeds, hoarseness, earache, nasal polyps, ear ringing		
Respiratory	Shortness of breath, asthma, difficulty breathing, emphysema, bronchitis, tuberculosis		
Cardiovascular	Heart attack, irregular heartbeat, heart murmur, chest pain, high blood pressure		
Gastrointestinal	Ulcer, hepatitis, weight changes, bowel changes, weight gain, weight loss, liver problems, intestinal disorders, reflux		
Genitourinary	Painful urination, difficulty urinating, blood in urine, renal disease/failure, frequent urination, kidney problems		
Hematologic	Blood clots, anemia, bleeding problems, hepatitis, blood transfusions, platelet disorder		
Endocrinology	Intolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue, diabetic		
Psychological	Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression, mental disorders, nervousness		
Skin	Color changes, infections, masses, open sores, hair changes, rash, itching, eczema		
Immunologic/Allergic	Dermatitis, latex allergy, hives, rash, asthma, hay fever, diabetes		
Other Medical Problems	Such as: Cancers, infectious disease, HIV, autoimmune disease, etc.		

Are you pregnant or nursing? ___ Yes ___ No If Yes how far along: _____

Are you planning on getting pregnant? ___ Yes ___ No

Do you use Sunscreen? ___ Yes ___ No Do you Tan indoor or outdoor? ___ Yes ___ No

At Doctor's Approach Dermatology we want to take an integrated approach to your health. We recommend that all our patients make a yearly appointment to see their:

Ophthalmologist or Optometrist
OB-GYN (women)

Dentist

Family Physician
Urologist (men)

Patient or Guardian Signature: _____ Date: _____

The provider signature below indicates this entire form was reviewed to include:
allergies · past medical history · family history · social history
surgical history · medications · review of systems.

Provider Signature: _____ Date: _____ Provider Signature: _____ Date: _____

(Doctor, Nurse Practitioner, Physician Assistant)

GUARANTEE OF PAYMENT FOR SERVICES

Thank you for choosing Doctor's Approach Dermatology for your skin care needs. In the interest of providing you with uninterrupted quality medical care, we are advising you of the following:

As the patient, it is your responsibility to know the extent of your insurance benefits and to be aware of the amount of your co-pay and deductible. These are due at the time of service.

Any procedure performed at the time of your office visit will be billed as a separate line item and may fall under your deductible.

If you are unaware of your copay \$25.00 will be collected at the time of your visit. (If this is more or less than your actual copay we will credit your account or send you a bill for the difference.)

It is our policy to collect copay, deductibles and balances on accounts prior to seeing our health care providers.

If for any reason your insurance company chooses not to cover your office visit or any procedures, **you will be responsible for payment at the time of service.** The cost for a visit can be provided to you in advance.

Your signature below indicates that you will be responsible for payment in full should your insurance company choose not to pay for a visit or procedure. Your signature below also indicates that you will take responsibility for a \$75.00 fee for each appointment in which the patient does not arrive or cancels without appropriate notice.

We request that a 48-hour notice be given for appointment cancellations, with the exception of cosmetic and surgical appointments. For cosmetic and surgical appointments a 72-hour cancellation notice is required.

Patients with 2 no-show appointments may be dismissed.

I, _____, have read and agree with the above statement and further agree to be responsible for all charges incurred.

Patient or Guardian Signature: _____ Date: _____

COSMETIC CONCERNS

What are your skin care or cosmetic concerns? Please circle all that apply

Facial Concerns

Brown spots	White heads	Black heads	Sun damage
Spider veins	Yellow/stained teeth	Redness	Loss of elasticity
Loss of facial volume	Wrinkles/lines	Enlarged pores	Sensitivity
Oily skin	Excess hair	Non-matching makeup	Uneven skin texture
Dry skin	Thin lips	Scars	Other:

Body Concerns

Scars	Excessive sweating	Appearance of chest	Fragile/brittle nails
Sagging skin	Excess fat	Dry body skin	Cellulite
Stretch marks	Body acne	Sun damage	Spider veins
Thinning hair	Other:	Other:	Other:

- I am interested in a FREE Medspa Consultation to talk about these concerns and learn about having them treated.
- I am NOT interested in cosmetic treatments.