DOCTOR'S APPROACH
DERMATOLOGY & SURGERY · MedSpa laser center · Skin Care PRODUCTS

Patient Information

Please present picture ID and Insurance card

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: _____ Pharmacy & Location: _____

Employer: _____ Occupation: _____

In case of emergency, notify: _____ Phone: _____
Relationship

Who is your family doctor? _____ Phone: _____

I hereby authorize Doctor's Approach to treat my child in my absence. _____
Parent Signature

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: _____

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 Doctor's Approach to communicate with my referring physician.

Patient or Guardian Signature: _____ Date: ___/_____/_____

2685 Jolly Rd *Okemos, Michigan 48864* *Main 517-993-5900*
Fax 517-332-1696 *www.DrsApproach.com* *Med Spa 517-993-5899*

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:

_____

_____

(Leave blank if none)

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 office notes, lab results, pathology results or other information regarding my condition to my family doctor or a physician to whom Doctor's Approach is referring me.

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: _____

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

What are your concerns today and when did the problem(s) begin? _____

Medical History

Select any of the following medical conditions that you currently have**.**

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other: _____ _____

Past Surgical History

Select any organs that you have had previous surgeries.

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Postate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

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

Medical History Continued

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Have Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other: _____

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

Do you have a family history of Skin Cancer? ☐ Yes ☐ No If yes which relative(s)? _____

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes which relative(s)? _____

List all current medications you take or apply regularly: _____

Do you need to take antibiotics before any surgeries or dental procedures? ☐ Yes ☐ No

If yes, what_____

List all allergies and reactions if known: _____

☐ I want my skin checked for skin cancer (Full Body Exam)

☐ I want my skin checked for skin cancer (Full Body Exam), and I will call at a later date to make an appointment.

☐ No, I do not want my skin checked for skin cancer. (Decline a Full Body Exam)

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy - _____

Quit Smoking:

- mm/dd/yyyy - _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (Please Choose one)

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

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

Social History Continued

How often do you exercise?	**What is your caffeine use?**
☐ Unspecified ☐ Several times a day ☐ Once a day ☐ A few times a week ☐ A few times a month ☐ Never ☐ Other _____	☐ Unspecified ☐ Several times a day ☐ Once a day ☐ A few times a week ☐ A few times a month ☐ Never ☐ Other _____

Cosmetic Concerns

What are you 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:

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

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
Constitutional	Fevers, chills, night sweats		
Skin	Color changes, infections, masses, open sores, hair changes, rash, itching, eczema		
Ears, Nose, Throat	Loss of hearing, trouble swallowing, nosebleeds, hoarseness, earache, nasal polyps, ear ringing		
Eyes	Visual loss or change, trauma, contacts, cataracts, blurred vision, glaucoma		
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		
Musculoskeletal	Arthritis, weakness, back pain, joint pain, cramps, stiffness, osteoporosis		
Neurologic	Seizures, stroke, balance changes, numbness/tingling, headaches, dizziness, migraines, myasthenia gravis		
Psychological	Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression, mental disorders, nervousness		
Endocrinology	Intolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue, diabetic		
Hematologic	Blood clots, anemia, bleeding problems, hepatitis, blood transfusions, platelet disorder		
Immunologic/Allergic	Dermatitis, latex allergy, hives, rash, asthma, hay fever, diabetes		
Other Medical Problems	Such as: Cancers, infectious disease, HIV, autoimmune disease, etc.		

Have you had an annual flu shot? Yes: _____ Date: _____ No: _____

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

Are you planning on getting pregnant? ____ Yes ____ No Is your menstrual cycle regular? ____ Yes ____ No

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

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

The Health Care 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)

Name: _____ D.O.B: _____

Guarantee of Payment for Services

Please Initial

Copay and Deductible Policy for Medical Patients

— As the patient, you are responsible to know the extent of your insurance benefits and to be aware of the amount of your co-pay and deductible.
— Copays and deductibles are due at the time of service, if you are unaware of the amount of your copay or deductible please contact the number on the back of your insurance card prior to your appointment.
— If you are unaware of your copay a standard $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 copays, deductibles and any outstanding balance on your account prior to seeing our health care providers.
— 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 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.

Cosmetic Guarantee of Payment for Services

— Doctor's Approach Dermatology & Surgery and Med Spa & Laser Center is unable bill your insurance company for cosmetic procedures.
— Payment is due at the time of service. We accept Cash, Visa, MasterCard, American Express, Discover, and financing through CareCredit.
— For cosmetic procedures at the Med Spa & Laser Center we do not accept personal or business checks for payment.
— If you would like more information or to apply for CareCredit, please visit www.carecredit.com.

No Show / Same Day Cancelations Policy

— Doctor's Approach Dermatology and Doctor's Approach Med Spa require a 48-hour notice be given for all appointment cancellations.
— A fee of $75.00 will be applied to your account for each appointment in which the patient does not arrive to or cancels without 48 hour notice.
— We require all new cosmetic clients at Doctor's Approach to prepay a deposit of $75.00 for your cosmetic consult with one of our health care providers (this excludes medical estheticians) to hold your appointment date and time. If you fail to cancel within 48 hours or no show your appointment you will forfeit your entire $75.00 deposit.
— If you receive a $75.00 No Show/Same Day cancelation fee from either Doctor's Approach Dermatology or Doctor's Approach Med Spa that fee must be paid prior to scheduling another appointment with Doctor's Approach Dermatology or Doctor's Approach Med Spa. Insurance does not cover these fees.
— Patients who no show or cancel the same day two or more times in a 12 month period, may be dismissed from Doctor's Approach Dermatology and Doctor's Approach Med Spa and denied any future appointments.

We understand that unavoidable circumstances may cause you to cancel within 24 hours, fees in this instance may be waived but only with management approval.

Patient or Guardian Signature: _____ Date: _____

Med Spa clients, cosmetic, and acne patients please complete. All other medical patients do not need to.

General Skin Health

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

How does your skin feel upon awakening? Oily: _____ Dry/ Itchy: _____ Normal: _____

After cleansing in the morning, how soon do you notice an oily shine?

Before Noon_____ Noon to 3pm _____ 3pm to evening _____ Not at all_____

*Please **CIRCLE** yes or no, and indicate times where applicable to the following:*

Have you been seen by a dermatologist in the past year? YES NO
If yes, what diagnoses? _____

Do you have a history of fever blisters or cold sores? YES NO

Do you wear contact lenses? YES NO

Do you have any permanent makeup or facial tattoos? YES NO

Does your skin typically heal quickly after surgery? YES NO

Do you experience thickening of scars or raised red, or darkened scars at incision sights after surgery? YES NO

Do you experience acne breakouts? YES NO

Following an acne breakout, does your skin turn red or darken? YES NO
If yes, for how long? _____

Do you experience any tightness or flaking of your skin? YES NO
If so, what time of day or time of the year? _____

Do you experience acne breakouts during your menstrual cycle? YES NO

Cosmetic Treatment History

Have you ever had any of the following procedures?

Laser Resurfacing YES NO Date: _____ Location: _____
Chemical Peel YES NO Date: _____ Location: _____
Microdermabrasion YES NO Date: _____ Location: _____
Botox YES NO Date: _____ Location: _____
Juvederm and Other Filler YES NO Date: _____ Location: _____
Cosmetic or reconstructive Surgery YES NO Date: _____ Explain: _____

Skin Care Routine

Please use the chart below to describe your skin care routine. Provide brand names if possible.

Product	AM Brand	PM Brand
Cleanser		
Toner		
Topical Treatment		
Moisturizer		
Eye Cream		
Sunscreen		
Exfoliators/Masks		
Other		

Patient or Guardian Signature: _____ Date: _____