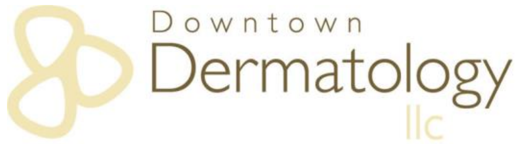

Date: ______________________

Patient Information

Name ____ **SS#**____________________
LAST FIRST MIDDLE INITIAL

Date of Birth ________________ **Gender** ❑ Male ❑ Female **Marital Status** ❑ Single ❑Married ❑Divorced ❑Widowed

Address ____
STREET CITY APT # STATE ZIP

Alternate Address ____
STREET CITY STATE ZIP

Phone *(check ☑ preferred contact number)*:
Home❑ ________________ **Cell**❑________________ **Work**❑ ________________

E-Mail ______________________**Do you authorize us to send you office-related information by email?** ❑Yes ❑No

Employer____________________ **Employer's Address** ______________________________
STREET CITY STATE ZIP

Primary Care Physician ________________________________**PCP Phone** ______________

____
STREET SUITE CITY STATE ZIP

Referring Physician ❑PCP or ❑Other Physician Name____________________ **Phone** ______________

If not referred by a physician, how did you hear about us? ❑Magazine ❑WebSite ____________ ❑Phone Book ❑Friend/Family ____________

Pharmacy ______________________ **Phone** ______________

Address ____
CROSSROADS CITY STATE ZIP

Person Responsible for Payment

Last Name: ________________ **First:** ____________ **MI:** ____ **SS#:** ________________

Relationship to Patient: ❑Spouse ❑Parent ❑Legal Guardian **Date of Birth:** _____/_____/_____

Address: ______________________**City:**______________ **State:** ____ **Zip:** ______

Home Phone: ______________ **Work Phone:** ______________ **Cell Phone:** ______________

INSURANCE: Please present insurance card(s) with this completed form

Primary Insurance Subscriber: ______________________ **Insurance Company:**______________

Date of Birth: _____/_____/______ **Group #:** ______________________ **Social Security #**______________

Secondary Insurance Subscriber: ______________________ **Insurance Company:** ______________

Date of Birth: _____/_____/______ **Group #:** ______________________ **Social Security #:**______________

Downtown Dermatology llc

Patient Name: ____________________

DOB: ____________

Emergency Contact

Name: ______________________________ **Phone:** (____) _____-________ **Relationship:** ____________________

Name: ______________________________ **Phone:** (____) _____-________ **Relationship:** ____________________

Parent/Legal Guardian (if under 18 years of age)

Name: ______________________________ **Phone:** (____) _____-_________ **Relationship:** ____________________

These questions are included to comply with new Federal Health guidelines -- we are required to ask for this information.				
	Ethnicity *(check one)*	❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑Declined or Unspecified
	Race *(check one)*	❑ American Indian/Alaskan Native	❑ Asian	❑ Native Hawaiian/Other Pacific Island
		❑ Black/African American	❑ White	❑Declined or Unspecified
	Preferred Language *(check one)*	❑ English	❑ Spanish	❑Declined or Unspecified

Medications

(please list all prescription & over-the-counter medications you are taking, including herbs, vitamins & supplements – along with the dosage)

If you currently DO NOT TAKE ANY MEDICATIONS, check this box: ❑

1) ______________________________ **5)** ______________________________

2) ______________________________ **6)** ______________________________

3) ______________________________ **7)** ______________________________

4) ______________________________ **8)** ______________________________

Medication Allergies/Reactions (please list medication and associated allergic reaction)

If you have NO KNOWN MEDICATION ALLERGIES, check this box: ❑

1) ______________________________ **4)** ______________________________

2) ______________________________ **5)** ______________________________

3) ______________________________ **6)** ______________________________

Current Medical Condition

REASON FOR TODAY'S VISIT:

Appointment Reminders, Laboratory Results and Billing

Please check how you would like to be notified:

- ❑ Home Telephone number:______________________________
- ❑ Cell Phone number:______________________________
- ❑ Work Number:______________________________

May we leave a detailed message?

❑Yes ❑No

You may discuss any of my medical information with the following individuals:

1.____

NAME RELATIONSHIP TELEPHONE

2.____

NAME RELATIONSHIP TELEPHONE

Patient Name: ______________________________ Patient Signature: ______________________________

PLEASE PRINT CLEARLY

Downtown Dermatology llc

Patient Name: ______________________________

DOB: ____________________

Past Medical History: (please check all that apply)

❑	Anxiety	❑	Depression	❑	Leukemia
❑	Arthritis	❑	Diabetes	❑	Lung Cancer
❑	Artificial joints	❑	End Stage Renal Disease	❑	Lymphoma
❑	Asthma	❑	GERD (Esophageal Reflux)	❑	Pacemaker
❑	Atrial fibrillation	❑	Hearing Loss	❑	Prostate Cancer
❑	BPH (Enlarged Prostate)	❑	Hepatitis	❑	Radiation Treatment
❑	Bone Marrow Transplant	❑	Hypertension	❑	Seizures
❑	Breast Cancer	❑	HIV/AIDS	❑	Stroke
❑	Colon Cancer	❑	Hypercholesterolemia	❑	Valve Replacement
❑	COPD (Chronic Lung Disease)	❑	Hyperthyroidism	❑	None
❑	Coronary Artery Disease	❑	Hypothyroidism	❑	
	Other ______________________________				

Past Surgical History: (please check all that apply)

❑	Appendix Removed	❑	Mechanical Valve Replacement	❑	Prostate Removed: Prostate Cancer
❑	Bladder Removed	❑	Biological Valve Replacement	❑	Prostate Biopsy
❑	Mastectomy	❑	Heart Transplant	❑	TURP (Prostate Resection)
❑	Lumpectomy	❑	Joint Replacement, Knee (L / R)	❑	Skin Biopsy
❑	Breast Biopsy	❑	Joint Replacement, Hip (L / R)	❑	Basal Cell Cancer Surgery
❑	Breast Reduction	❑	Joint Replacement last 2 years	❑	Squamous Cell Carcinoma Surgery
❑	Breast Implants	❑	Kidney Biopsy	❑	Melanoma Surgery
❑	Colectomy: Colon Cancer Resection	❑	Kidney Removed	❑	Spleen Removed
❑	Colectomy: Diverticulitis	❑	Kidney Stone Removal	❑	Testicles Removed
❑	Colectomy: IBD	❑	Kidney Transplant	❑	Hysterectomy: Fibroids
❑	Gallbladder Removed	❑	Ovaries Removed: Endometriosis	❑	Hysterectomy: Uterine Cancer
❑	Coronary Artery Bypass	❑	Ovaries Removed: Cyst	❑	None
❑	PTCA (Cardiac Angioplasty)	❑	Ovaries Removed: Ovarian Cancer		
❑	Other ______________________________				

Downtown Dermatology llc

Patient Name: ______________________________

DOB: ______________________

Skin Disease History: (please check all that apply)

❑ Acne	❑ Dry Skin	❑ Poison Ivy
❑ Actinic Keratoses	❑ Eczema	❑ Precancerous Moles
❑ Asthma	❑ Flaking or Itchy Scalp	❑ Psoriasis
❑ Basal Cell Skin Cancer	❑ Hairloss - Alopecia	❑ Squamous Cell Skin Cancer
❑ Blistering Sunburns	❑ Hay Fever/Allergies	❑ Melanoma
❑ Other:		None

Do you wear Sunscreen? ❑Yes ❑No If yes, what SPF? ___________

Do you tan in a tanning salon? ❑Yes ❑No

Do you have a family history of Melanoma? ❑Yes ❑No

If yes, which relative(s)? ____

Cautions: (please check all that apply)

Currently have a changing mole	❑Yes	❑No	Allergy to topical antibiotic ointments	❑Yes	❑No
Pacemaker	❑Yes	❑No	Allergy to lidocaine	❑Yes	❑No
Defibrillator	❑Yes	❑No	Rapid heart beat with epinepherine	❑Yes	❑No
Artificial joints in past two years	❑Yes	❑No	Require antibiotics prior to procedures	❑Yes	❑No
Artificial heart valve	❑Yes	❑No	Yeast infections with antibiotics	❑Yes	❑No
Pregnancy or planning pregnancy	❑Yes	❑No	Upset stomach with antibiotics	❑Yes	❑No
Immunosuppression	❑Yes	❑No	Currently taking blood thinners	❑Yes	❑No
Allergy to adhesive	❑Yes	❑No			

Social History: (Please check all that apply)

❑ Not sexually active	❑ Current every day smoker	❑ Do not consume alcohol	❑ Drug use - type
❑ Sexually active with one partner	❑ Current some day smoker	❑ Consume less than one alcoholic beverage a day	❑ IV drug use
❑ Sexually active with more than one partner	❑ Former Smoker	❑ Consume 1-2 alcoholic beverages a day	
❑ Same gender partner	❑ Never Smoker	❑ Consume 3 or more alcoholic beverages a day	

Downtown Dermatology llc

Patient Name: ______________________________

DOB: ____________________

Review of Systems:

Are you currently experiencing any of the following?

(Please check ☑Yes or ☑No for the following)

Rash	❑Yes ❑No	Cough	❑Yes ❑No	Blurry Vision	❑Yes ❑No
Bleeding Problems	❑Yes ❑No	Joint Aches	❑Yes ❑No	Night Sweats	❑Yes ❑No
Difficulty Healing	❑Yes ❑No	Muscle Weakness	❑Yes ❑No	Unintentional Weight Loss	❑Yes ❑No
Problems with scarring (hypertrophic or keloid)	❑Yes ❑No	Thyroid Problems	❑Yes ❑No	Abdominal Pain	❑Yes ❑No
Hay Fever	❑Yes ❑No	Depression	❑Yes ❑No	Bloody Urine	❑Yes ❑No
Wheezing	❑Yes ❑No	Anxiety	❑Yes ❑No	Bloody Stool	❑Yes ❑No
Fever or Chills	❑Yes ❑No	Headaches	❑Yes ❑No	Other: ______________	❑Yes ❑No
Chest Pain	❑Yes ❑No	Neck Stiffness	❑Yes ❑No		
Shortness of Breath	❑Yes ❑No	Sore Throat	❑Yes ❑No		

Aesthetic Questionnaire

Do you have any moles whose appearance bothers you?	❑Yes ❑No
Have you ever considered removing unwanted or excessive hair?	❑Yes ❑No
Do you have more wrinkles than you would like?	❑Yes ❑No
Are you bothered by the redness or the fine vessels on your face?	❑Yes ❑No
Do you have brown sunspots that you would like to get rid of?	❑Yes ❑No
Did you ever consider tightening the skin on your face?	❑Yes ❑No
Are you bothered by frown lines or deepening furrows?	❑Yes ❑No
Do you have any questions about BOTOX, Dysport, Restylane, or Juviderm?	❑Yes ❑No
Ever wonder about the possibility of tightening skin in “problem areas” of the body?	❑Yes ❑No
Have you ever considered doing something “rejuvenating” to your skin but were scared of surgery?	❑Yes ❑No
Are you interested in a simple way to have your skin glow and also have your make-up go on smoother?	❑Yes ❑No
Are you interested in products to diminish visible signs of aging?	❑Yes ❑No

Are you concerned about short and/or thinning eyelashes	❑Yes ❑No
Would you like to discuss split ear repair?	❑Yes ❑No
Are you concerned about small veins in the legs that do not cause pain?	❑Yes ❑No
What is the biggest concern regarding your skin? ________________________________	

Consent to the use & disclosure of personal health information

I hereby consent to the use and disclosure of personal health information by Downtown Dermatology, LLC, its workforce, and its business associates for the purposes of carrying out treatment, health care operations, and obtaining insurance payment. *A copy of the Notice of Privacy Practices for Protected Health Information (Privacy Notice) has been made available to me and it describes my rights as well as the potential uses and disclosures of my protected health information by Downtown Dermatology, LLC.*

- You have the right to revoke this consent at any time by notifying the office in writing, except to the extent the office has taken action and reliance upon your consent.
- You have the right to request to restrict the manner in which your protected health is used. The office is not required, however, to agree to such requested restrictions. If the office agrees to the requested restriction, our office will honor the request and it will be binding.
- We have reserved the right to change the privacy practices described in the Privacy Notice in accordance with the law.
- You may obtain a copy of the Privacy Notice and revisions by making such request in writing or in person at our office.

Patient Signature____ Date: __________________________

Release and Assignment

I, the undersigned have insurance coverage with ____
and assign directly to Downtown Dermatology, LLC. all medical benefits. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I am responsible to pay any deductible and/or co-payment and non-covered services under the terms of my insurance. I understand that I am financially liable in the event of non-payment: I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

Patient Signature: _______________________________________ Date: _____________________________

Medicare Patients

I request that payment of authorized Medicare benefits to be made directly to Downtown Dermatology, LLC., on my behalf for any service furnished by that physician. I authorize any holder of medical information about me to release to CMS and its agents needed to determine these benefits payable for related services. I understand my signature request that be made and authorize release *of* medical information necessary to pay claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible for deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _______________________________________ Date: _______________________________

Non-Insurance (Cash) and/or cosmetic patients

I understand that payment in full is expected at time of service for all services performed by Downtown Dermatology, LLC. I also adhere to the current policy of Downtown Dermatology, LLC. regarding collection fees incurred to collect balance in full.

Patient Signature: _______________________________ Date: __________________________

Insurance Assignment and Financial Policy

Please read and sign this statement before we agree to accept assignment of benefits directly from your insurance company. This avoids any misunderstandings and facilitates the processing of your insurance claim.

Payment Policy

MEDICARE: We are participating providers of the Medicare program. We will accept assignment of all claims. Patients are responsible for meeting their annual deductible and co-pays at the time of service. We do file with secondary supplement carriers.

HMO, PPO, or OTHER MANAGED CARE PATIENTS: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services at the time of service. Patients without the required referral from your PCP at the time of appointment will be asked to reschedule. If you prefer to be seen without the required referral, payment will be due at the time of service.

COMMERCIAL PATIENTS: Patients who are covered by private, commercial plans, in which our physician is not contracted, are responsible for all fees. The balance left after payment from your insurance will be billed to you.

Insufficient Fund/Return Check Policy

I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payment on my account thereafter and I will be obligated to pay a returned check fee of $25.00.

Payment is due at the time of service

I understand that office visit charges are payable on the day service is rendered. I authorize Downtown Dermatology, LLC to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Downtown Dermatology, LLC and myself. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand I am financially liable in the event of non-payment: I agree to pay the collection agency's cost and/or court cost and reasonable attorney fee.

Patient Signature: ____Date ______________________________