Advanced Dermatology

Registration (Please Print)

Date _____ Cell Phone _____ Home Phone _____

Name _____ Name you prefer to be called _____
Last First Middle

Address _____
City State Zip

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Social Security #_____ Whom may we thank for referring you? _____

Preferred Language:_____ Race & Ethnic Group:_____

Employer _____ Work Phone _____
Name Address

Occupation_____ If Student: ❑ Part-time ❑ Full-time Email Address _____

In case of emergency, who should be notified? _____ Phone _____

Do we have permission to: Leave a message on your answering machine? ❑ Yes ❑ No
Leave a message at your place of employment? ❑ Yes ❑ No
Discuss your medical condition with any member of your household? ❑ Yes ❑ No

If yes, Whom: _____ Relationship: _____

Person responsible for account (information <u>required</u> if patient is a minor):

_____
Name Address City State Zip

Insurance Company_____Policyholder_____

Policyholder Employer_____ Policyholder Social Security #_____

Patient relationship to Policyholder: ❑ Self ❑ Child ❑ Spouse ❑ Other Policyholder Date of Birth _____

In order to establish optimal relations with our patients and avoid any misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR YOUR PART OF THE CHARGES. We accept VISA, MasterCard, American Express and Discover for your convenience.

If we are participating providers for your insurance company, we will file your claim. However, any unmet deductible or co-pay is due at the time of service. <u>Please be aware that "Co-Pays" usually cover office visits.</u> <u>Surgical procedures usually fall under your deductible.</u> If we do not "participate" with your insurance company, you will be given a statement of office services which should be sent (along with your insurance form) to your insurance company so you may be reimbursed directly.

Please notify us at least two business days in advance if you are unable to keep your appointment. This courtesy allows someone else to be treated - a courtesy you would want if the circumstances were reversed.

Your signature below indicates that you understand and accept these policies. In addition, your signature certifices that you understand that you are financially responsible for all charges whether or not paid by insurance. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor, when an assigned claim is filed.

_____ _____ Circle One: Self Parent Guardian
Signature of Patient or Legal Guardian Date

_____
Print Name

A GUARDIAN OR ADULT SIGNATURE IS REQUIRED IF PATIENT IS UNDER AGE 18

Please present your insurance cards and photo ID to our receptionist. She will make copies and return them to you promptly.

Advanced Dermatology
Renaissance Medical Spa

Patient Name: _____ Date: _____ Birthdate: _____

What Pharmacy do you use? _____ What City or Zip Code? _____

Past Medical History (please check all that apply):

- ❑ Anxiety
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ BPH
- ❑ Bone Marrow
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV / AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Pacemaker
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Transplantation
- ❑ Valve Replacements

Past Surgical History (please enter past surgical history):

_____

_____

_____

_____

Skin Diseases History (please check all that apply):

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking/Itching scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Psoriasis
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Squamous Cell Skin Cancer

Patient Signature:_____ Date:_____

Patient Name: _____ Date: _____ Birthdate: _____

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, list relative:_____

Medications (please list all current medications):_____

_____

Allergies (please enter all allergies):_____

_____

Social History (please check all that apply):

Smoker: ❑ Current ❑ Past ❑ Never Drug Use: ❑ Yes ❑ No Alcohol Use: ❑ Yes ❑ No

Sexually Active: ❑ Yes ❑ No

Cautions (please check all that apply):

Review of Systems - Have you or are you currently experiencing any of the following?

Bleeding Problems ❑ Yes ❑ No Healing Problems ❑ Yes ❑ No Scarring ❑ Yes ❑ No

Other Symptoms: _____

Do you have an allergy to adhesive? ❑ Yes ❑ No Do you have an allergy to lidocaine? ❑ Yes ❑ No

Are you allergic to any topical antibiotic ointments? ❑ Yes ❑ No If so, what? _____

Have you ever had difficulty stopping bleeding? ❑ Yes ❑ No Are you on any blood thinners? ❑ Yes ❑ No

Do you require antibiotics prior to a surgical procedure? ❑ Yes ❑ No

Do you have an artificial joint replacement? ❑ Yes ❑ No Do you have a pacemaker? ❑ Yes ❑ No

Have you ever had MRSA? ❑ Yes ❑ No If yes, when and what body locations? _____

Do you have a defibrillator? ❑ Yes ❑ No Do you have an artificial heart valve? ❑ Yes ❑ No

Do you experience rapid heart beat with epinephrine? ❑ Yes ❑ No

Are you pregnant or currently trying to get pregnant? ❑ Yes ❑ No