CHOICE DERMATOLOGY®

PATIENT INFORMATION

Full Name: _____
Date of Birth: _____ SSN: _____
Address: _____
City/State/Zip:_____ Gender: M / F / OTHER
Primary Phone (preferred): _____ (Mobile/Home/Work)
Secondary Phone: _____ (Mobile/Home/Work)
Email: _____
Race(s): White___ Black or African American___ Hispanic___ Asian___ Decline to specify___
Emergency Contact: _____
Phone Number: _____ Relationship: _____
Primary Physician: _____ Phone: _____
Address:_____City/State/Zip:_____

INSURANCE INFORMATION

Insurance Company: _____
Address: _____
Phone: _____
Identification Number: _____ Group: _____

PRIMARY INSURED (if different from patient)

Name of Responsible Party: _____
Date of Birth: _____ Relationship: _____ Gender: M / F
Address: _____
Primary Phone: _____ Secondary Phone: _____

EMPLOYMENT INFORMATION

Company: _____
Address: _____

If You Have Additional Insurance, Please Fill Out the Following Information:

Secondary Insurance Company: _____
Phone: _____ Address: _____
ID Number: _____ Group Number: _____
Subscribers Named: _____
Date of Birth: _____ Relationship to patient:_____

CHOICE DERMATOLOGY®

Medical History (please circle any medical condition you have)

- Anxiety
- Coronary Artery Disease
- High Cholesterol
- Arthritis
- Depression
- Hyper or Hypothyroidism
- Asthma
- Diabetes
- Leukemia
- Arrhythmia: Irregular Heartbeats
- Kidney Disease
- Lung Cancer
- BPH
- GERD
- Lymphoma
- Bone Marrow Transplant
- Hearing Loss
- Prostate Cancer
- Breast Cancer
- Hepatitis
- Radiation Therapy
- Colon Cancer
- High Blood Pressure
- Epilepsy
- Stroke
- HIV / AIDS
- Chronic Obstructive Pulmonary Disease (COPD)

Other Conditions: _____

Surgical History (please circle all that apply)

- Kidney Biopsy
- Appendix Removal
- Kidney Removal (right, left)
- Bladder Removal
- Kidney Stones Removal
- Mastectomy (right, left, bilateral)
- Kidney Transplant
- Breast Biopsy (right, left, bilateral)
- Endometriosis/Ovaries Removed
- Breast Reduction
- Ovarian Cyst Removal
- Breast Implants
- Ovaries Removed/Ovarian Cancer
- Colon Cancer Resection
- Prostate Removal
- Colostomy: IBD
- Prostate Biopsy
- Gallbladder Removal
- Prostate: TURP
- Heart: Coronary Artery Bypass Surgery
- Prostate Biopsy
- Basal Cell Carcinoma Surgery
- Heart: PTCA
- Heart: Valve Replacement (mechanical/biological)
- Squamous Cell Surgery
- Heart: Transplant
- Joint Replacement: Knee (right, left, bilateral)
- Melanoma Surgery
- Joint Replacement: Hip (right, left, bilateral)
- Spleen Removal
- Uterus/Hysterectomy: Fibroids
- Uterus/Hysterectomy: Uterine Cancer
- Joint Replacement in the Last 2 Years

Other Surgeries: _____

CHOICE DERMATOLOGY®

Do you have any of the following skin conditions? (please circle all that apply)

Acne	Basal Cell Carcinoma	Precancerous Moles
Dry Skin	Psoriasis	Melanoma
Actinic Keratosis	Itchy / Scaly Scalp	Poison Ivy
Allergies	Squamous Cell Carcinoma	Other_____
Eczema	Blisters or Sunburns	_____

Do you use sunscreen? Yes / No, if yes, what SPF? _____
Do you tan in a tanning salon? Yes / No
Does anyone in your family have a history of melanoma? Yes / No, if yes, which relative?
_____

Medications(please list all medications you take, including vitamins, supplements, herbal remedies, and prescription or over-the-counter drugs; please write the milligrams, e.g., aspirin, ibuprofen)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Vaccines: Please write the dates (or "don't know") of your most recent vaccines:
Influenza: _____ Pneumonia: _____ Tetanus: _____ COVID-19: _____

Food and Drug Allergies, including lidocaine and latex (please specify reactions):
_____
_____

Pharmacy and Location: _____

Social History (please check what applies)

Alcohol Consumption:
- I do not drink alcohol __
- Less than 1 drink per day __
- 1-2 drinks daily __
- 3+ drinks per day __

Tobacco Use:
- I have never smoked __
- I currently smoke daily: Yes / No

CHOICE DERMATOLOGY®

I have smoked in the past __ Total number of years smoking ___

ACKNOWLEDGEMENT AS OF PRIVACY PRACTICES ELECTRONIC ACCESS AND OFFICE PROCEDURES

A scanned copy of this authorization shall be considered as valid as the original. This authorization may be revoked by me in writing

1.PRIVACY PRACTICES AND RELEASE OF MY PROTECTED HEALTH INFORMATION

I may refuse to sign this acknowledgement:

-I have received a copy of choice Dermatology LLC's notice of privacy practices.

-By authorize the physician to release any information acquired in the course of my examination or treatment to my referring physician and/or to my insurance carrier, information needed to determine benefits

2. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby assign payment directly to the Physician for the Surgical and/or Medical benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to Physician for those services. I understand that 1 am financially responsible for charges not covered by Insurance.

3.CANCELLATION POLICY

I understand that if I cancel or change my appointment with less than 24 hours notice, I may be charged $25.00. The charge for cancelation of a cosmetic appointment, surgery or patch testing less than 24 hours from your appointment is $100, these include for Botox, Facials, Filler, Peels, Laser,TruSculpt, Microneedling and any other cosmetic procedures. Deposits are required to hold a spot for facials, Peels and other cosmetic treatments/procedures, deposits are non-refundable if cancellation occurs within 24 hours of appointment time.

4. INSURANCE VERIFICATION

It is your responsibility to provide up to date medical insurance Information and to notify us of any changes In your Insurance coverage. You are personally responsible for all charges incurred. Failure to provide accurate insurance information that results in non-payment for services, or denial of claims from insurance, will result in charges to your account plus an additional fee of $25 for inactive or terminated insurance. This charge is added to account for processing costs to the practice.

5.COLLECTIONS

If you fail to make any payment due to Choice Dermatology, we have the right to refer your account to a third party for collection (a collection agency). You will be responsible for all costs associated with collections including an Administration Fee of $35.

6.ELECTRONIC MEDICAL RECORD ACCESS

I am aware that I will be assigned a portal for electronic access to my medical record. The practice will provide me a username and password via paper or email.

7.REFERRALS

Many Insurance carriers require a referral from your Primary Care Physician. It is your responsibility to obtain a referral prior to your visit

CHOICE DERMATOLOGY®

_____ _____

Signature of patient or parent if patient is a minor ***Date***

OPTIONAL: AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION TO MY DESIGNATED THIRD PARTIES

I _____ allow for the following person(s) to receive medical information on my behalf and/or about me:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Third Party Name	**Relationship to Patient**	**Patient's Signature**

For Office Use Only:

We have attempted to obtain the patient's written consent regarding our privacy practices, but consent could not be obtained because:

_____ The patient refused to sign.

_____ Communication barriers prevented obtaining consent.