PATIENT INFORMATION

Date_____

Patient Name_____

Birthdate _____/_____/_____ Age_____

Address_____ City_____ Zip_____

How did you hear about us?_____

Doctor's name, if you were referred_____

Home phone #_____ Cell phone #_____

Social Security Number _____

Insurance Name_____ Secondary Insurance Name_____

Member ID #_____ Group #_____

Policy Holder_____ Policy Holder's SSN_____

What is your relationship to policy holder? Self___ Spouse___ Child___ Other_____

Emergency Contact_____ Phone #_____

Office and Financial Policies

Welcome and thank you for choosing the Center for Advanced Dermatology for your dermatology care. We are committed to the highest professional standards of skin care while providing patients with a comfortable and friendly environment. We hope that by providing you with our policies in advance we can prevent any misunderstandings during your time with us.

Initial_____ **Insurance:** When making an appointment with Dr. Chi, it is your responsibility to confirm with your insurance company (or companies if you have a secondary policy) that the physician is currently under contract with your plan. Each plan has its own stipulations regarding the coverage of, and payment for, medical services; therefore it is your responsibility to know your plan's benefit policies including co-payments, prior to your appointment. Ultimately all insurance deductibles, co-payments, and denials for primary or secondary insurance policies will be your financial responsibility.

Initial_____ **Medicare/Medical Patients Only:** Center for Advanced Dermatology is not under contract with Medical; therefore whatever Medicare does not cover will be the financial responsibility of the patient.

Initial_____ **Check-in:** We do our best to keep on schedule, so please arrive for your appointment on time. If you arrive more than 30 minutes past your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced. Please bring your current insurance card(s) with you to your first visit. On subsequent visits, it will be your responsibility to notify us of any changes in your address and/or insurance information; otherwise, you will be responsible for any omissions, financial or otherwise, related to these changes.

Initial_____ **Copays/Outstanding Balances:** Please be prepared to pay any past balances on your account. Payment of co-pays and non-covered services will be required at time of service. For your convenience, we accept cash, checks for amounts under $200, MasterCard, Visa, and Discovercard.

Initial_____ **Out-of-Network:** If your insurance is with a company that Center for Advanced Dermatology does not contract with, you must pay for your services at the time of service.

Initial_____ **Non-covered Services:** If you are coming for a non-covered service, please be prepared to pay for the service in full at the time of service. Cosmetic procedures including, but not limited to, sclerotherapy, Botox, laser procedures, hair reduction, photorejuvenation, chemical peels, dermabrasion and fillers are not covered by insurance and claims will not be filed for them.

Initial_____ **Refunds/Exchanges**: Partial refunds for incompletely used cosmetic packages may be given within 30 days of purchase. No refunds will be given after 30 days; however, any unused balance may be applied towards other services and/or products. Products may be returned for a full refund within 30 days of purchase if unopened and in their original packaging.

Initial_____ **NO SHOWS and Late Cancellations:** We require a 24-hour advance notice if you must cancel your appointment. Each patient is allowed one NO SHOW or late cancellation. Any NO SHOW or late cancellation thereafter will result in a $75 charge and you will be required to secure any subsequent appointments with a credit card.

Initial_____ **Minors:** The parent(s) or guardian(s) must accompany a minor for their first visit to our office, and are responsible for providing current insurance information and/or payment in full for services provided. For follow-up visits, unaccompanied minors must have an authorization note for medical treatment signed by a parent or guardian before treatment can be rendered

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information as necessary for insurance filing and pre-certification by signing this statement.

_____ DOB: _____

Patient Name

_____ Date: _____

Signature of Patient or Responsible Party

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Dermatology Medical History

Patient: _____ Date of Birth:: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:
Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin ❑ Other _____

Social History:
Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS) ? ❑ YES ❑ NO

Please answer the following questions:
(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient ❑ Medical Assistant _____ Initials

_____ Signed by Patient ___/___/___ Date

_____ Reviewed by ___/___/___ Date