OFFICES: circle
NY PA PS FM BA AL CO WI ES OS BC RW SU

Visit our website www.GetMeGreatSkin.com

ADVANCED DERMATOLOGY, P.C.
CENTER FOR LASER & COSMETIC SURGERY

OFFICE USE ONLY
_____ SIGNATURES
_____ COMPLETE

PLEASE FILL OUT BOTH SIDES OF THESE TWO FORMS (8 sides) AND RETURN TO FRONT DESK

NAME: _____ Date: _____
(Last, First, Middle)

DATE OF BIRTH: ____/____/____ AGE: _____ S.S. #: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

*CELL #: ( ) _____ HOME PHONE # ( ) _____

☐ Opt-in to receive text reminders (preferred by patients)

*E-MAIL: _____

You are granting Advanced Dermatology, P.C. permission to use your e-mail for emergency contact, educational material and other communications. Your e-mail will not be distributed to 3rd parties.

SEX: ☐ M ☐ F **OCCUPATION:** _____

☐ Check if Minor (less than 18) Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race _____ Ethnicity _____ Preferred Language _____

REFERRED BY: (circle one) DOCTOR / SIGN / FRIEND or FAMILY / ADS / ARTICLES / INTERNET: INSURANCE; YELLOW PAGES; OUR WEBSITE; ZOC DOC; YELP; HEALTHGRADES; ON-LINE SEARCH
OTHER: _____

NAME OF REFERRING FRIEND: _____

NAME OF REFERRING DOCTOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: ( ) _____

NAME OF PRIMARY CARE DOCTOR _____

IF NOT LISTED ABOVE: _____

MEDICAL EMERGENCY CONTACTS: (LIST NAMES & PHONE)

NAME: _____ PHONE: ( ) _____

NAME: _____ PHONE: ( ) _____

Pharmacy Name: _____ CITY: _____ STREET: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE #: ( ) _____

SPOUSE'S / PARENT'S / GUARDIAN'S NAME: _____

EMPLOYER: _____ PHONE: ( ) _____

• HEALTH INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: _____

NAME OF INSURED: _____

RELATIONSHIP TO PATIENT: ☐ PARENT ☐ SPOUSE ☐ SELF ☐ OTHER ☐M ☐F

DATE OF BIRTH: ____/____/____ INSURANCE ID #: _____

S.S. # OF INSURED: _____

EMPLOYER/GROUP NAME: _____ GROUP #: _____

CO-PAY AMOUNT $: _____

DO YOU HAVE A DRUG OR PRESCRIPTION PLAN? YES / NO

* If ever a change in insurance information or medical condition it is important you inform us.

SECONDARY INSURANCE NAME: _____

NAME OF INSURED: _____

RELATIONSHIP TO PATIENT: ☐ PARENT ☐ SPOUSE ☐ SELF ☐ OTHER ☐M ☐F

DATE OF BIRTH: ____/____/____ INSURANCE ID #: _____

S.S. # OF INSURED: _____

THIS OFFICE IS NOW ACCREDITED TO DISPENSE CUSTOM MEDICATIONS AT THE TIME OF YOUR VISIT.
ARE YOU INTERESTED? ☐ YES ☐ NO

• PLEASE READ THIS STATEMENT BELOW CAREFULLY AND SIGN:
All information on all eight sections of this form including the **Medical History & Financial Policy Form** are true and complete. I **agree to inform you on subsequent visits if any Medical History or Insurance Information changes, or if I move.** My signature will also be used as "signature on file" for insurance purposes including any medical information necessary to process the claim. I give permission for medical photographs to be taken and they may be used for educational purposes.
I hereby assign my insurance benefits to be paid directly to Advanced Dermatology, P.C.

I have read Advanced Dermatology, P.C.'s financial policy on page 4 and agree that I am ultimately responsible for all non-covered services, and broken appointments, rendered to me or my dependents. You are granting Advanced Dermatology, P.C. permission to use your e-mail for emergency contact, educational material and other communications. Your e-mail will not be distributed to 3rd parties.

_____ _____
Print Patient's Name Patient's Signature or Guardian

I have read the HIPAA consent, on page 3 and if I do not sign this form below, Advanced Dermatology P.C. may decline to provide treatment to me. My signature below states that I agree with its contents.

_____ _____
Print Patient's Name Patient's Signature or Guardian

 * *Required information*

Rev 11/1/15

HIPAA CONSENT

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent Advanced Dermatology, P.C. may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Advanced Dermatology, P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices.
Advanced Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Dermatology, P.C.'s Privacy Officer.

With my consent Advanced Dermatology, P.C. may call or text my home or cell phone or other designated location and leave a message on voicemail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, prescription renewals, lab results, Insurance items and all other Protected Health Information* ("PHI") and return calls requesting a call back.

Other Designated Numbers:

(_____) _____-_____ Home / Office / Cell / Other: _____
(_____) _____-_____ Home / Office / Cell / Other: _____
(_____) _____-_____ Home / Office / Cell / Other: _____

With my consent, on the front page Advanced Dermatology, P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

◆ I agree that my PHI may be shared with my spouse & the following other people.

_____ _____
_____ _____

With my consent, Advanced Dermatology, P.C. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Advanced Dermatology, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent.

***THE COMPLETE HIPAA GUIDELINES ARE AVAILABLE AT THE FRONT DESK FOR YOUR REVIEW.**

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FINANCIAL POLICY

Thank you for selecting Advanced Dermatology, P.C. for your dermatological cares. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical and/or any laboratory fees, the following is provided.

HMO/PPO/Other Insurance Coverage: If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a driver's license.

All co-payments are due prior to seeing the physician. If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

If you have coverage with an insurance carrier with which we do not participate ("out of network"), payment is due at the time of service. We will provide you with a receipt that you can submit to your carrier for reimbursement, if applicable.

Medicare: Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to that particular carrier any remaining balance. You will also be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Laboratory: Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

Self-Pay Patients (Will Pay): Patients with no insurance, the guarantor is responsible for the bill at the time of service.

Cosmetic Patients: Deposits are required prior to the date of the procedure. The balance of the payment is required prior to the procedure being performed.

Payments: We utilize a guaranteed check service, which automatically deducts the amount of your check from your account immediately. This is similar to how your credit or debit card works by showing us if funds are available in your account.

Refund Policy: We do not offer refunds on medical and cosmetic procedures.

Cancellation Policy: A $25 charge will be made for all no show appointments unless 24 hours notice is given. A $100 charge will be made for all no show surgical appointments unless 24 hours notice is given.

Returned Checks & Collections: A charge of $25 will be made for all returned checks. In the event that any action is brought to collection, you agree to pay any reasonable collection costs and/or attorney fees.

OFFICES: circle

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MEDICAL HISTORY: PLEASE FILL OUT BOTH SIDES OF THIS FORM

PRINT NAME: _____

REASON FOR TODAY'S VISIT/CHIEF COMPLAINT: _____

_____

When was your last physical examination? _____

Physician's Name: _____

Phone #: _____

We strongly recommend a complete body skin exam for skin cancer screening.
Would you like to schedule an appointment for that exam? ☐ Yes ☐ No

Have you ever been seen in any **Advanced Dermatology, P.C.** Office? ☐ Yes ☐ No
When? _____ Which office? _____
Seen by any other Dermatologist? ☐ Yes ☐ No
Whom/When/For what problems? _____

1. HAVE YOU EVER HAD OR HAVE ALLERGIES (MEDICATIONS):

Allergic reaction to:			Reaction/Type/Date
Penicillin	☐ Yes	☐ No	_____
Lidocaine	☐ Yes	☐ No	_____
Latex	☐ Yes	☐ No	_____
Other _____	☐ Yes	☐ No	_____

2.TOBACCO USE: ☐ Former Smoker ☐ Never Smoker ☐ Current Every Day Smoker
☐ Current Some Day Smoker ☐ Unknown if Ever Smoked

3. PAST MEDICAL HISTORY:

Arthritis	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Asthma/Bronchitis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Type/When_____			Keloid/Enlarged Scars	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Platelet Condition	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Insulin Dependent	☐ Yes	☐ No	Mitral Valve Prolapse/ Valve Replacement	☐ Yes	☐ No
Drug or Alcohol Abuse	☐ Yes	☐ No	Pacemaker/Defibrillator	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Poor/Non Healing Wounds	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Hepatitis Type_____	☐ Yes	☐ No	Venereal/Sexual Disease	☐ Yes	☐ No

Additional: _____

4. Any Special Non-Listed Health Issues (i.e.Downs, Autism, etc.): ☐ Yes ☐ No
Explain: _____

Past Operation(s)/Other Diseases: (what/when/explain)_____

_____

3. FAMILY HISTORY:

Basal Cell Carcinoma	☐ Yes	☐ No
Squamous Cell Carcinoma	☐ Yes	☐ No
Melanoma	☐ Yes	☐ No
Who/Location: _____		
Allergies	☐ Yes	☐ No
Type: _____		
Asthma/Bronchitis	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Other Skin Conditions/Explain: _____		

_____

_____

_____

4. SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes ☐ No
How Much? _____
Do you use drugs? ☐ Yes ☐ No
Regular Periods? ☐ Yes ☐ No
Use birth control? ☐ Yes ☐ No
Are you pregnant now? ☐ Yes ☐ No
Are you breastfeeding now? ☐ Yes ☐ No
Ever been pregnant? ☐ Yes ☐ No
Number of Pregnancies: _____

5. MEDICATION (S): ☐ Yes ☐ No

CURRENT ORAL MEDICATIONS, HERBS, HEALTH FOODS, SUPPLEMENTS, BIRTH CONTROL PILLS, ETC._____

_____

_____

_____

Aspirin/Aleve/Advil/etc.	☐ Yes	☐ No	Accutane	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No	Past use of Accutane?	☐ Yes	☐ No
			If Yes When? _____		

CURRENT TOPICAL & OVER-THE-COUNTER MEDICATIONS & CREAMS: _____

_____

_____

6. PERSONAL SKIN HISTORY:

Basal Cell Carcinoma	☐ Yes	☐ No
Squamous Cell Carcinoma	☐ Yes	☐ No
Melanoma	☐ Yes	☐ No
Location/Year/Depth _____		
Allergies:		
Food	☐ Yes	☐ No
If Yes What Type: _____		
Environment	☐ Yes	☐ No
If Yes What Type: _____		
Psoriasis	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
When/Where: _____		

Eczema ☐ Yes ☐ No
Have you ever had a sunburn?# of times____ ☐ Yes ☐ No
Other Skin Conditions:_____

_____

_____

_____

Have you ever had any laser, cosmetic or plastic surgery procedures performed on you? ☐ Yes ☐ No
Procedures & When:_____

_____

LIST OTHER OPERATIONS, SURGERY OR DISEASES:_____

_____

_____

GENERAL INFORMATION: Height_____ Weight _____lbs.
OTHER PERTINENT INFORMATION: _____

WE OFFER A WIDE VARIETY OF SERVICES - (Partial Listing)

Are you interested in any of these services?

☐	Yes	☐	No	Age Spots/Sun Spots
☐	Yes	☐	No	Beautiful Eyes
☐	Yes	☐	No	Broken Blood Vessels/Spider Veins
☐	Yes	☐	No	Chemical Peel for Pigmentation/Melasma
☐	Yes	☐	No	Double Chin (Kybella, CoolSculpting Mini)
☐	Yes	☐	No	Earlobe Repair
☐	Yes	☐	No	Excessive Fat/Cellulite/Liposuction
☐	Yes	☐	No	Facial Wrinkles: **Botox®/Dysport®**
☐	Yes	☐	No	**Fillers:** Restylane®/ **Respylane Lyft®** /Radiesse®/Juvederm® Ultra, Ultra Plus, Voluma®, Belotero®, Sculptra®, Fat
☐	Yes	☐	No	Growth Removal
☐	Yes	☐	No	Natural Hair Transplants℠
☐	Yes	☐	No	Laser Treatments for Acne
☐	Yes	☐	No	Laser Treatments for Nail Fungus
☐	Yes	☐	No	Laser for Psoriasis or Loss of Pigmentation
☐	Yes	☐	No	Microdermabrasion
☐	Yes	☐	No	Nail Fungus - Genesis Plus **CoolSculpting®**
☐	Yes	☐	No	Non-Surgical Skin Tightening - **Ulthera®/Thermage®**
☐	Yes	☐	No	Non Surgical Fat Reduction – **Liposonix/ Bella Contour/Zerona®/Ulthera®**
☐	Yes	☐	No	Patch Testing for Skin Allergies
☐	Yes	☐	No	Permanent Hair Removal (Reduction)
☐	Yes	☐	No	Plastic Surgery
☐	Yes	☐	No	Scars-Acne, Traumatic, etc.
☐	Yes	☐	No	Skin Rejuvenation
☐	Yes	☐	No	Skin Tightening - **Thermi-RF/Thermi Smooth**
☐	Yes	☐	No	Stretch Marks
☐	Yes	☐	No	Tattoo Removal
☐	Yes	☐	No	Underarm Sweat Reduction - Mira Dry®
☐	Yes	☐	No	Vaginal Rejuvination (thermiVa)
☐	Yes	☐	No	Varicose Veins
☐	Yes	☐	No	Wrinkle/Jowls/Rejuvenation **with downtime - Pixel**
☐	Yes	☐	No	Wrinkle/Jowls/Rejuvenation **without downtime (Ulthera®/Fraxel®)**

SKIN CARE LINE FOR:

☐ Acne	☐ Reducing Fine Lines	☐ Skin Rejuvenation
☐ Hair Products	☐ Skin Discolorations	☐ Sun Screens
☐ Moisturizers	☐ Hair Growth	☐ Brown Spots

Any Other Product(s) Interested In? _____

IMPORTANT PLEASE READ

INSTRUCTIONS FOR EXAM ROOM

- Please remove chewing gum, candies or any food prior to exam.
- Please turn off all electronic devices when leaving waiting room.
- Please take facial make-up off prior to being examined.
- If nail disorder, please remove nail polish (we can provide remover).
- If getting undressed, please put clothing on chair and not on counter.
- Please keep on only underpants and bra (optional) when undergoing complete body exam.
- If any hand problems we usually like to examine feet, so please remove your shoes & socks.

Thank you for choosing **Advanced Dermatology, P.C.**, a premier dermatology practice specializing in conditions of skin, hair and nails in adults and children. In addition to medical conditions we are famous for our laser and cosmetic surgery and for the latest in medical treatments. We presently feature the most skin and cometic lasers of any multi-facility group practice in New York.

Please visit our very informative website www.GetMeGreatSkin.com. On the website we invite you to view our before and after procedure book, brochures, and videotapes on Cosmetic & Medical Conditions and articles written by our doctors and interviews of our doctors in the press. We also offer, on our website, information on most skin conditions, fact sheets on medications & other resources. You can check our website for upcoming events and other informative information.

www.GetMeGreatSkin.com