



PLEASE FILL OUT BOTH SIDES OF THESE TWO FORMS (4 sides) AND RETURN TO FRONT DESK

OFFICE USE ONLY
SIGNATURES
COMPLETE

Date _____

NAME: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE#: () _____

CELL / PAGER #: () _____

E-MAIL: _____

SEX: M F OCCUPATION: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE #: () _____

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

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

EMPLOYER: _____ PHONE #:() _____

• MEDICAL EMERGENCY CONTACTS: (LIST NAMES & PHONE #'S)

NAME: _____ PHONE #: () _____

NAME: _____ PHONE #: () _____

Sign up for e-mail, educational information and special Advanced Dermatology, PC discounts. Your information will remain confidential.

Visit our websites: www.AdvancedD.com, www.DrSkinInfo.Org/AdvancedD
(Advanced Dermatology PC© 2008)

• 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 _____

SECONDARY 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 #: _____

• PLEASE READ THIS STATEMENT AND SIGN BELOW:

All information on all four sides of this chart including the Medical History, HIPAA Consent & Financial Policy Form are true and complete. **I agree to inform you on subsequent visits if any Medical History or Insurance Information changes.** This 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's financial policy and agree that I am ultimately responsible for all non-covered services and broken appointments.

I have read the HIPAA consent, and if I do not sign this form, Advanced Dermatology PC may decline to provide treatment to me.

Print Patient's Name

Patient's Signature

Date

Print Name of Legal Guardian

Legal Guardian's Signature

Thank you for choosing **Advanced Dermatology PC**, 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 and plastic surgery with the latest in medical treatments. We presently feature the most skin and cosmetic lasers of any multi-facility group practice in New York.

Please visit our very informative website @ **AdvancedD.com**. or for detailed Dermatology information visit our 2nd site-www.DrSkinInfo.org/advancedd. For your convenience 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. Look at our web-site and bulletin board for upcoming events and informative information.

For information on most skin conditions, fact sheets on medications & other resources, you can also visit us at:

www.Dr.SkinInfo.Org/AdvancedD.com

IMPORTANT PLEASE READ INSTRUCTIONS FOR EXAM ROOM

1. Please turn off cell phones and pagers when in examination room.
2. Please remove chewing gum, hard candies or mints prior to exam.
3. Please take facial make-up off prior to being examined.
4. If nail disorder, please remove nail polish (we can provide remover)
5. If getting undressed, please put clothing on chair and not on counter.
6. Please keep on only underpants and bra (optional) when undergoing complete body exam.
7. If any hand problems we usually like to examine feet, so please remove your shoes & socks.

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/surgery 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.

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 amount 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 charge will be made for broken appointments unless 24 hours notice is given.

Returned Checks & Collections: A charge of \$20 will be made for all returned checks. In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees.

PRINT NAME: _____

REASON FOR TODAY'S VISIT: _____

We strongly recommend a complete body skin exam for skin cancer screening on initial visit. Do you want? It does not take long. Yes No

Have you ever been seen in any **Advanced Dermatology** office (including this office)? Yes No

When _____ Which office? _____

Seen by any other Dermatologist? Yes No
Whom/When/For what problems? _____

HAVE YOU EVER HAD OR HAVE:

1. ALLERGIES: (Medications)

Allergic reaction to any medicines: Penicillin Yes No
Lidocaine Yes No

Other: _____

What happened: _____

2. PAST MEDICAL HISTORY:

Asthma Yes No
Bleeding Problems Yes No
Cancer Yes No
Diabetes Yes No
Drug or Alcohol Abuse Yes No
Glaucoma Yes No
Hay Fever Yes No
Heart Disease Yes No
Hepatitis Yes No
HIV/AIDS Yes No
Hypertension Yes No
Keloid/Enlarged Scars Yes No
Lung Disease Yes No
Pacemaker/Defibrillator Yes No
Past Operation(s)/Other Diseases:
(what/when/explain) _____

Poor/NonHealing Wounds Yes No
X-Ray/Radiation Therapy Yes No
Location: _____

3. FAMILY HISTORY:

Basal Cell Carcinoma Yes No
Squamous Cell Carcinoma Yes No
Melanoma Yes No
Location/Year _____
Allergies Yes No
Type _____
Hay Fever Yes No
Asthma/Bronchitis Yes No
Psoriasis Yes No
Eczema Yes No
Other Skin Conditions: _____

Explain: _____

4. SOCIAL HISTORY:

Are you pregnant Yes No
Do you smoke Yes No
Do you drink alcohol? Yes No
Do you use drugs? Yes No

5. MEDICATION(S)

CURRENT ORAL MEDICATIONS, HERBS, HEALTH FOODS (including birth control pills)

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

6. PERSONAL HISTORY:

Basal Cell Carcinoma Yes No Blood Thinners Yes No
Squamous Cell Carcinoma Yes No Use of Accutane Yes No
Melanoma Yes No When: _____
Location/Year _____ Have you ever had a sunburn? # of times ___ Yes No
Allergies- Other Skin Conditions: _____
Food/Environment Yes No Explain: _____
Type _____
Hay Fever Yes No
Asthma/Bronchitis Yes No Have you had any cosmetic
Psoriasis Yes No procedures? Yes No
Eczema Yes No Explain: _____
Aspirin Yes No

LIST OTHER OPERATIONS, SURGERY OR DISEASES: _____

GENERAL INFORMATION:

Height _____ Normal BP _____ Weight _____ lbs.

OTHER PERTINENT INFORMATION: _____

• **REFERRED BY:** (circle one) DOCTOR / YELLOW PAGES (Big or Little) / SIGN / INS. BOOK/ INS. PLAN / FRIEND / FAMILY / NEWSPAPER / INTERNET / WEBSITE NAME: _____

OTHER: _____

• **DR. or FRIEND'S NAME:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: () _____

NAME OF PRIMARY CARE DOCTOR _____
IF NOT ABOVE:

REQUIRED SIDE
ADVANCED DERMATOLOGY PC

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION-HIPAA CONSENT

With my consent Advanced Dermatology PC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Advanced Dermatology's PC 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 PC 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 PC Privacy Officer.

With my consent Advanced Dermatology PC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and insurance items and return calls requesting a call back.

With my consent, Advanced Dermatology PC 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.

With my consent, Advanced Dermatology PC 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 PC 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.

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

ARE YOU INTERESTED IN OUR SKIN CARE LINE FOR:

- | | | |
|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Moisturizers
Eye, Face, Body | <input type="checkbox"/> Skin Rejuvenation/Healthier
Skin |
| <input type="checkbox"/> Getting Rid of Irregular
Skin Discolorations | <input type="checkbox"/> Reducing Fine Lines/
Wrinkles | <input type="checkbox"/> Sun Screens/Different
Types |
| Any Other Product(s) Interested In _____ | | |

WE OFFER THE FOLLOWING PROCEDURES:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Age Spots/Sun Spots |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Beautiful Eyes |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Botox®: Forehead/Eyelid Wrinkles |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chemical Peel for Pigmentation/Melasma |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Earlobe Repair |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Excessive Fat/Cellulite/Liposculpture/Liposuction |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Facials/Aesthetician Services |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fillers: Restylane®, Fat, Radiesse®, Collagen®,
Hylaform®, Sculptra® |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Growth Removal |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hair Transplants-Natural SM Technique |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Laser Treatments for Acne/Microdermabrasion |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Patch Testing for Skin Allergies |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Permanent Hair Removal (Reduction) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scars-Acne, Traumatic, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spider Veins |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stretch Marks |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattoo Removal |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thermage® -Non-Surgical Skin Tightening |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Varicose Veins |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wrinkle/Joules/Rejuvenation with downtime |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wrinkle/Joules/Rejuvenation without downtime
(Fraxel®) |

We offer Cosmetic and reconstructive procedures for men & women

FACE AND HEAD

- | | | |
|------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear Surgery |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid Lift-Upper
& Lower |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Facelift |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neck Lift |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nose Surgery |

SKIN

- | | | |
|------------------------------|-----------------------------|-----------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scar Revision |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Facial Suturing |

BODY

- | | | |
|------------------------------|-----------------------------|-------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arm Lift |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Buttock Contouing |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tummy Tuck |

BREASTS

- | | | |
|------------------------------|-----------------------------|---------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breast Augmentation |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breast Lift |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breast Reduction |