

PATIENT REGISTRATION INFORMATION

Name _____
FIRST MI LAST

Preferred Name (If different from above) _____ E-mail _____
 Would you like to be on our email list?

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____
Please check one of the boxes to indicate preferred contact number for automated appointment confirmation

Social Security Number: _____ Date of Birth: _____ Sex: M F

Marital Status: Minor Single Married Widowed Divorced Separated

Occupation: _____

Employer's Name & Address: _____

Patient's Medical Doctor (Internist/Family Practitioner/Pediatrician): _____

Pharmacy Name, Location & Phone Number: _____

How did you hear about us? Referred by? _____

EMERGENCY CONTACT/SPOUSE OR PARENTS/GUARDIAN INFORMATION

Name: _____ Phone (____) _____ Relationship: _____
(H) (W) (C)

PAYMENT INFORMATION

GUARANTOR: (person to be billed for co-payments, deductibles or any other balance)

Name: _____ Phone: _____ Relationship to patient: _____

Occupation: _____ Employer _____

Address (If different from patient): _____

PRIMARY INSURANCE:

Name of insurance Co: _____

Policy Holder's Name: _____ Date of Birth: _____ ID or SS#: _____

Relation to patient: _____

What is the name of your Prescription carrier? (if applicable) _____

SECONDARY/SUPPLEMENTAL INSURANCE:

Name of Insurance Co: _____

Policy Holder's Name: _____ Date of Birth: _____ SS#: _____

Relation to patient: _____

Office Policy: Payment is due at the time of your visit for any deductibles, co-payments, unpaid Medicare or insurance balances and any cosmetic procedures or skin care products. We appreciate your cooperation in settling your account at each office visit. If your insurance plan is responsible for payment, please present your insurance card to our reception desk.

Patient Signature (Parent/guardian if patient is a minor) Date

DERMATOLOGY FIRST VISIT

Ref: _____ **INS:** _____

Patient Name _____ Date _____

Reason for visit: _____

Medical Allergies: _____ **Current Medications:** _____

Do you or your family have a history of any of the following?
(Check only those that apply)

Are you currently having problems with any of the following?

	<u>YOU</u>	<u>FAMILY</u>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Dysplastic moles	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (including skin)	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	
Lung Problems	<input type="checkbox"/>	
Stomach problems	<input type="checkbox"/>	
Kidney problems	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	
Cosmetic surgery	<input type="checkbox"/>	if yes, when _____

	YES	NO
General Health: (e.g. fever, weight loss)	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/bowels	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

Number of children/age(s) _____ Occupation _____ Hobbies/leisure activities _____

Females: Are you pregnant or planning to become pregnant in the near future? **YES** **NO**

Do you smoke? **YES** **NO** How many packs per day? _____ How many years? _____

How much alcohol do you drink? _____

Reviewed _____ Date _____

(MD signature)

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ Date: _____

Skin conditions of concern and procedures/products of interest to you (please check all that apply).

- | | |
|---|---|
| <input type="checkbox"/> BOTOX® Cosmetic (Botulinum Toxin Type A) | <input type="checkbox"/> Spider Vein Treatments |
| <input type="checkbox"/> PhotoFacial | <input type="checkbox"/> Removing Facial Veins |
| <input type="checkbox"/> Juvederm or Restylane Therapy | <input type="checkbox"/> Laser Resurfacing |
| <input type="checkbox"/> Skin Rejuvenation | <input type="checkbox"/> Hair Removal |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Tattoo Removal |
| <input type="checkbox"/> Micro-Dermabrasion | <input type="checkbox"/> Acne and Acne Scars |
| <input type="checkbox"/> Facials and Eye Treatments | <input type="checkbox"/> Liver Spots/Age Spots |
| <input type="checkbox"/> Laser Skin Tightening | <input type="checkbox"/> Retin A or Renova |
| <input type="checkbox"/> Mesotherapy | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Other, please specify _____ | |

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>	<i>True Age</i>	<i>Older Than</i>		
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

<i>Not Concerned</i>	<i>Somewhat Concerned</i>	<i>Very Concerned</i>		
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the condition of my skin.

<i>Not Concerned</i>	<i>Somewhat Concerned</i>	<i>Very Concerned</i>		
1	2	3	4	5

My main concerns are:

What other services would you like to see us offer?

Thank You!



Patient Name

I have read and received a copy, if requested, of the **Notice of Privacy Practices** _____ (Initials)
(Please Read Blue Laminated Sheet)

CANCELLATION POLICY

If I cannot make my scheduled appointment, I will make all reasonable attempts to cancel my appointment with an advance notice of at least 24 hours to allow another patient or patients to be scheduled in my appointment slot. If I fail to cancel my appointment with at least 24 hours advanced notice, I agree to pay a cancellation fee. I understand that this is not a fee that is billable to my insurance company.

I also understand that this policy is necessary due to the extended waiting time for appointments and the high cost of running this medical practice. Please be aware that we do not frivolously charge patients for missed appointments. If you have a legitimate reason for being unable to keep your appointment such as a death in the family or a medical illness, we accept these explanations. Our primary concern is for patients who forget their appointments, are too busy to keep their appointments or change their mind and fail to give us adequate time to fill their appointment slot with another patient.

_____ (Initials)

FINANCIAL POLICY

Pierre Skin Care Institute will be happy to bill your insurance company for your care provided you give us all the information we need. Even though you have insurance coverage, remember that paying for your treatment is your personal responsibility. You agree to give us permission to bill your insurance company on your behalf. If your policy does not allow us to do that (as is the case with HMOs), then all charges for services rendered are due and payable on the day of service. Please remember to inform us of any changes to your insurance coverage.

All co-payments are due at the time of service. You will also need to pay your portion of the charges as they are incurred. This includes the annual deductible, co-insurance, and charges not covered by your insurance company. While our office policy does not allow us to extend credit, we can debit your American Express, Discover, MasterCard or VISA card for these charges.

Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important. Also, your insurance company may request additional information from you. They will not pay your claim until they receive the information, so please send it immediately.

Once you have been billed for the balance (your statement will say "Amount Due" at the bottom right), you will have a 30 day grace period from the date of your statement to pay your balance in full. After 30 days, you will be charged a \$15 late fee.

In the interest of providing the best service for all of our patients at the lowest possible cost, we are implementing a service which reduces operating expenses yet maintains that personal service which we know you require and deserve. As of September 1, 2005 all accounts that go beyond 90 days past due are automatically transferred to Transworld Systems Inc., a collection agency, for accounts receivable assistance.

If you contact us within the 30 day grace period regarding the inability to pay your balance in full, Pierre Skin Care Institute may, at its discretion, arrange for payments to be made on the balance. However, we are unable to offer discounts on or waive your balance (co-pay, co-insurance, deductible) because the government has deemed it illegal to do so, unless there is written documentation of financial hardship.

Patient Signature (Parent/guardian if patient is a minor)

Date