Pierre
Skin Care Institute

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)

	YOU	**FAMILY**
Psoriasis	☐	☐
Eczema	☐	☐
Dysplastic moles	☐	☐
Cancer (including skin)	☐	☐
Melanoma	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	
Heart Problems	☐	
Lung Problems	☐	
Stomach problems	☐	
Kidney problems	☐	
Arthritis	☐	
Tuberculosis	☐	
Hepatitis	☐	
Cosmetic surgery	☐ if yes, when______________	

Are you currently having problems with any of the following?

	YES	**NO**
General Health: (e.g. fever, weight loss)	☐	☐
Eyes	☐	☐
Ears/Nose/Throat	☐	☐
Heart	☐	☐
Lungs	☐	☐
Stomach/bowels	☐	☐
Kidneys	☐	☐
Arthritis	☐	☐
Headaches/Seizures	☐	☐
Depression/Anxiety	☐	☐
Thyroid	☐	☐
Bleeding Disorder	☐	☐

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)

PATIENT REGISTRATION INFORMATION

Name ____
FIRST MI LAST

Preferred Name (If different from above) ________________________**E-mail**__________________________
Email is used for appt reminders & newsletters

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? ____

EMERGENGY CONTACT/SPOUSE OR PARENTS/GUARDIAN INFORMATION

Name: _______________________ Phone (_____) _________________ Relationship: ___________________
(H) (W) (C)

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 (if applicable):
Name of Insurance Co: ____

Policy Holder's Name: _________________________Date of Birth: __________ID or SS#: ________________

Relation to patient: ____

Office Policy: Payment is due at the time of your visit for any deductibles, co-payments, unpaid insurance balances and any cosmetic procedures or skin care products. We appreciate your cooperation in settling your account at each office visit.

By signing below, I acknowledge that I am the guarantor of this account; I am responsible for co-pays, deductibles or any other balances due to Pierre Skin Care Institute.

___________________________________ _____________________________ ________

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

Innovative solutions for healthy, beautiful skin

____

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 understand I may have to pay a $50 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

As a courtesy, Pierre Skin Care Institute will 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 insurance takes more than 60 days to respond to your claim, your services will be considered your financial responsibility at which time you may seek reimbursement from your insurance company if you wish to do so. Please remember to inform us of any changes to your insurance coverage.

All co-payments are due at the time of service. You are responsible for paying 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 accept the following credit cards as forms of payment: American Express, Discover, MasterCard and VISA. For your convenience, you may complete this section to authorize Pierre Skin Care Institute to charge your credit card for any balances due after your insurance company has made payment to our office for services.

Name: ______________________________ Card#: ______________________________

Signature: ______________________________ Exp. Date: ______________________________

Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and its 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.

Payments are due upon receipt of the statement. After 30 days, you will be charged a $25 late fee. Accounts that are more than 90 days past due are transferred to an outside collection agency and expenses/fees will be added to your account balance. You agree to be liable for all such collection expense, legal fees and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $25

I have read and understand all the terms of this policy. By my signature below, I attest that I fully understand each item and agree to the terms above.

______________________________ ______________

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

TREATMENT TO MINORS

Many times parents find themselves unable to accompany their minor children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant permission to Pierre Skin Care Institute to treat my child when they arrive at the office unaccompanied.

_______________________________________ ________________
Signature of Parent Date

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

This agreement is required if you wish your minor child to be seen unaccompanied.

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied, I authorize Pierre Skin Care Institute to charge my major credit card (listed below) under the following circumstances:

Initials
______ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.
______ For whatever reason, should my account fall into a 45 day or later (after the date of service) category, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

______ A receipt for charges will be mailed to my address.
VISA MasterCard American Express Discover
Credit Card #: ___________________________________
Expiration Date: ____/____/____

Name as it appears on the credit card:

____
Print Name

____ ____________
Signature Date

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: ________________________________ Date: ____________________

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

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

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.

Younger Than		*True Age*		*Older Than*
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.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
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.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	**2**	**3**	**4**	**5**

My main concerns are:

____

What other services would you like to see us offer?

____

Thank You!

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