PIERRE
SKIN CARE INSTITUTE
Uncompromising Service. Beautiful, Natural Results.

DERMATOLOGY FIRST VISIT **Ref:_____ INS:_____**

Patient Name _____ Date _____

Pharmacy Name, Location & Phone Number: _____

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)

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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

____ (Initial) I grant permission to Pierre Skin Care Institute to send me a secured email, or leave a message regarding my condition and/or my bill on the following numbers provided above: Home ___, Work___, Cell___ (check all that apply)

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): _____

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

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_____ If minor, name of parent/guardian: _____

PRINT Patient Name **PRINT parent/guardian**

I acknowledge that I have received a copy of the office **Notice of Privacy Practices**. The Notice explains how my protected health information is used and disclosed. _____ (Initials)

_____ (Initial) I grant permission to Pierre Skin Care Institute to send me a secured email, or leave a message regarding my condition and/or my bill on the phone numbers provided: Home _____, Cell_____

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.

(Optional): 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#: _____ Billing Zip Code:_____

Exp Date:_____ Signature: _____ Contact me before charging my credit card. Yes____ No____

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

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
- ☐ Kybella
- ☐ Spider Vein Treatments
- ☐ Removing Facial Veins
- ☐ Laser Resurfacing
- ☐ Hair Removal
- ☐ Acne and Acne Scars
- ☐ Liver Spots/Age Spots
- ☐ Retin A or Renova
- ☐ Skin Care Products
- ☐ 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.

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?

_____

_____