



### **Patient Information**

Name \_\_\_\_\_ Gender \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status \_\_\_\_\_  
Home Phone (    ) \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
Cell Phone (    ) \_\_\_\_\_ Emergency Phone: (    ) \_\_\_\_\_  
Email \_\_\_\_\_ Emergency Relationship \_\_\_\_\_  
Primary Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

### **Insurance Policy Holder**

Responsible Party Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (    ) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

\*\*Payment of co-pays & private pay fees are due at time of service. If my insurance company does not make remittance within 60 days after services are rendered or if there is a deductible, I am responsible for any remaining balance. There will be a \$25 fee for any returned checks.

\*\*I understand that Apex Dermatology does not participate with Medicaid nor any HMOs nor non-contracted insurers, (including Blue Shield plans with ID numbers beginning with XED, XEK, XET, XES, XEF, XEW) and I am responsible for any and all balances.

\*\*I hereby authorize payment of the surgical and/or medical benefits directly to the physician/medical office. I also understand I am responsible for any portion of the bill not covered by my insurance or not paid within 60 days.

\*\*I hereby authorize release of information for insurance claim purposes; copy of the above is as valid as the original. I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read and agree to the above and grant the request of authorization.

Signed \_\_\_\_\_ Date \_\_\_\_\_



Name: \_\_\_\_\_

## **Notice of Privacy Practices Acknowledgement Form**

The Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully, as it explains:

- How this office will use and disclose your protected medical information.
- Your privacy rights with regard to your protected health information.
- This office's obligations concerning the use and disclosure of your protected health information.

I acknowledge that I have received a copy of the office Notice of Privacy Practices and understand my rights as well as the doctors' rights. I agree to allow my doctor to exercise their right and disclose my Individually Identifiable Health Information (IIHI) when required to do so by law. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

\_\_\_\_\_  
Signature of Patient

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian (if patient is under 18 years old)

Date \_\_\_\_\_

### **Please initial your preference:**

\_\_\_\_\_ I give permission for detailed phone messages to be left with a person or machine answering at this number: (    ) \_\_\_\_\_

\_\_\_\_\_ I give permission to receive text messages at this number: (    ) \_\_\_\_\_

\_\_\_\_\_ I do **NOT** give permission to leave messages regarding my medical care.

Do you give permission to discuss your account with any family member?   ☐ Yes   ☐ No

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Birth of Family Member \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **OR:** Last four digits of their SSN # \_\_\_\_\_



Name: \_\_\_\_\_

### **History and Intake Form**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Purpose of visit \_\_\_\_\_

Referred By \_\_\_\_\_ Primary Physician \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Hobbies (optional) \_\_\_\_\_

#### **Past Medical History:** (Please check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Pacemaker         |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression              | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Artificial joints   | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> HIV/AIDS          |
| <input type="checkbox"/> Defibrillator       | <input type="checkbox"/> End Stage Renal Disease |  |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Hearing Loss            |  |

#### **Past Surgical History:** (Please check all that apply)

- ☐ Breast Implants  
☐ Organ Transplant  
☐ Joint Replacement  
☐ Other \_\_\_\_\_

#### **Skin Disease History:** (please check all that apply)

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> Acne                | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Melanoma       |
| <input type="checkbox"/> Actinic Keratosis   | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Atypical Moles |
| <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Dry Skin  | <input type="checkbox"/> _____          |

Skin Cancer: ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ \_\_\_\_\_

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon? ☐ Yes ☐ No If yes, how often? \_\_\_\_\_

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative? \_\_\_\_\_

#### **Medications:** (Please list all current medications or supplements)

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Name: \_\_\_\_\_

**Allergies:** (Please list all allergies) \_\_\_\_\_

**Social History:** Tobacco use? ☐ Current ☐ Past ☐ Never Current drug use? \_\_\_\_\_

**Alerts:** (please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Allergy to Adhesive                               | <input type="checkbox"/> Allergy to lidocaine                |
| <input type="checkbox"/> Allergy to topical antibiotics                    | <input type="checkbox"/> Artificial heart valve              |
| <input type="checkbox"/> Allergy to latex                                  | <input type="checkbox"/> Blood thinners                      |
| <input type="checkbox"/> Artificial joint replacement                      | <input type="checkbox"/> MRSA                                |
| <input type="checkbox"/> Defibrillator                                     | <input type="checkbox"/> Breastfeeding                       |
| <input type="checkbox"/> Pacemaker   | <input type="checkbox"/> Pregnant or trying to get pregnant? |
| <input type="checkbox"/> Require antibiotics prior to a surgical procedure | <input type="checkbox"/> Rapid heart beat with epinephrine   |

**Are you currently experiencing any of the following?** (Please check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Rash              | <input type="checkbox"/> Changing Mole      | <input type="checkbox"/> Joint aches / pain / swelling |
| <input type="checkbox"/> Muscle weakness   | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Fever / chills                |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Healing Problems   |  |

**Apex typically sends electronic prescriptions. Please supply the following:**

Pharmacy Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

**Let us know if you would like updates from Apex Dermatology (optional):**

- ☐ I would like to receive information about the practice, events, or skin health by email.
- ☐ I would like to receive information about cosmetic events and special offers by email.

**Please check all that apply:**

- ☐ I would like to book a cosmetic consultation.
- ☐ I am bothered by wrinkles, spots, skin tags and/or broken blood vessels.
- ☐ I would like to discuss options to make me look more youthful and/or rested.
- ☐ I would like to learn more about products that will refresh, renew and restore my skin.
- ☐ I am interested in body contouring or skin tightening.
- ☐ I am interested in feminine rejuvenation.



Name: \_\_\_\_\_

### **Cancellation Policy**

We understand that unplanned issues can come up and you may need to cancel or reschedule an appointment. However, when a patient does not arrive for a scheduled appointment, another patient loses an opportunity to be treated. Therefore, we have the following cancellation policies:

**MEDICAL PATIENTS:** We require at least 24 hours notice (or the prior Friday, if your appointment is on a Monday) to cancel or reschedule a medical appointment. If the appointment is canceled or rescheduled with less than this time, a \$50 fee will be assessed.

**COSMETIC PATIENTS:** Booking a cosmetic procedure requires a 10% or other required deposit. We require at least 72 hours notice (or the prior Thursday, if your appointment is on a Monday) to cancel or reschedule a cosmetic appointment. If the appointment is canceled or rescheduled with less than this time, the deposit is non-refundable.

Thank you for being a valued patient and for your understanding and cooperation.

I understand and accept the Cancellation Policy for Apex Dermatology and agree to pay the cancellation fees if I do not give the required notice as listed above.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

### **Cultural Background Information (optional)**

We would like you to tell us your racial and ethnic background so that we can periodically review our patient data and make sure that everyone is receiving the highest quality of care. This information is collected for the Federal electronic medical record assessment system. Your cooperation is greatly appreciated.

Which category best describes your race/ethnicity?

- ☐ White / Caucasian
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Decline to answer

What is your primary language?

- ☐ English
- ☐ Other \_\_\_\_\_
- ☐ Decline to answer