Patient Demographic Form

Patient Name _____
Last name **First name**

Patient's Date of Birth _____ Age _____

Address _____
Street **City** **State** **Zip Code**

Telephone _____
Home **Mobile** **Work**

Email Address _____

Employer _____

Marital Status (circle) Single Married Widowed Divorced Partnered

Emergency Contact _____
Full Name **Relationship to Patient** **Phone Number**

Primary Care Physician _____
Last Name **First Name** **Phone Number**

Referring Physician _____
Last Name **First Name** **Phone Number**

☐ NO CHANGES SINCE LAST OFFICE VISIT

Primary Insurance	**Secondary Insurance**
_____	_____
Insurance Company Name	**Insurance Company Name**
_____	_____
Subscriber's Name if Different from Patient	**Subscriber's Name if Different from Patient**
_____	_____
Subscriber's ID Number	**Subscriber's ID Number**
_____	_____
Group Number	**Group Number**
_____	_____
Subscriber's Birthdate	**Subscriber's Birthdate**

PATIENT OR GUARDIAN SIGNATURE_____ Date_____

Patient Name _____ **Date of Birth _____**

Patient Acknowledgment and Authorizations

I authorize ERderm to conduct examinations, and preform procedures as are medically required to administer treatment and medications as deemed necessary or advisable.

Erderm is hereby authorized to release a complete report of services rendered, diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's workers' compensation insurance company, other third-party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other Intermediaries responsible for payment of services rendered. The release of information consent may be revoked at any time by giving written notice.

If release of information is refused, the patient will be held responsible for payment of all charges for services rendered. In consideration of medical goods and services provided by ERderm, I give all rights, title and interest to the medical/surgical/supply reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefits including Medicare Part B. I remain fully responsible for payment of any and all charges not covered by insurance or Medicare.

Patient Assignment of Benefits

ERderm will bill all primary and secondary insurances, but I am ultimately responsible for payment for the services and any supplies/equipment I receive. I hereby assign to ERderm, any insurance or other third-party benefits available for healthcare services provided to me. I understand that ERderm has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to ERderm, I agree to forward to the ERderm all health insurance and other third-party payments that I receive for services rendered to me immediately upon request. I understand that my signature requests payment be made directly to ERderm. I authorize release of medical information necessary to pay the claim. A photocopy of this assignment is to be considered as the original.

Patient Financial Policy

Thank you for choosing ERderm as a healthcare provider. We are committed to your treatment being a successful experience. Please help us maintain accurate records by filling out forms legibly, and inform us if any changes need to be updated on your account (for example: address, telephone number, medical insurance, etc). Copayments are due at the time of service. ERderm reserves the right to send out specimens to an outside laboratory for special staining purposes, pathologic interpretation, and/or to obtain a second opinion. ERderm is not responsible for any outside facility charges that may be incurred. It is your responsibility to know and understand your specific insurance plan and what benefits are provided. This fee is forfeited without canceling or rescheduling with a minimum of 24 hour notice. We accept all major credit cards, checks, and cash. Please review ERderm's complete Patient Financial Policy attached for more information.

I have read and agree with the Patient Acknowledgment and authorizations, Assignment of Benefits, and Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient or Guardian Signature: _____ Date: _____

Patient Name _____ **Date of Birth _____**

Channel of Communication Request

You have the right to request how we communicate with you. We may communicate with you by phone, text, email, or US Mail including use of automated communication devices. I hereby request the use of the following communication channels for information related to my personal health, treatment, or payment for treatment. This request supersedes any prior request for confidential communications I have made. This permission is valid for one year from the date signed. You may revoke your authorization to receive further calls or messages at any time. The revocation does not have to be in writing. The ability to receive treatment from ERderm is not contingent upon your communication choices

Please circle all that apply and indicate with options(s) you prefer:

Preferred Contact Method (Circle all that apply): Phone Email Text

Primary Phone (_____)_____-_____ Alternate Phone (_____)_____-_____

_____ DO NOT leave messages on my voicemail

_____ OKAY TO leave messages on my voicemail

If you are unavailable, ERderm has permission to speak with: _____
Preferred Email Address:_____

Notice of Privacy Practices

I hereby acknowledge that I was offered and/or received a copy of ERderm Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Any questions regarding the Privacy Practices of ERderm should be directed to our Office Manager, Brittany Van Leeuwen. She can be reached via email at Brittany.van.leeuwen@erderm.com

I would like to receive a copy of any amended Notice of Privacy practices (circle one): Yes / No

Patient or Guardian Signature: _____ Date: _____

Patient Name _____ **Date of Birth _____**

Past Medical History: (please circle all that apply)

Anxiety	Arthritis	Asthma
Artificial Fibrillation	Breast Cancer	Colon Cancer
COPD	Coronary Artery Disease	Diabetes
Hearing Loss	Hepatitis	Hypertension
HIV/AIDS	Hypercholesterolemia	Hyperthyroidism
Hypothyroidism	Leukemia	Lung Cancer
Lymphoma	Pacemaker	Radiation Treatment
Seizures	Stroke	

Other _____

_____

Past Surgical History: _____

_____

Skin Disease History: (please circle all that apply)

Acne	Asthma	Actinic Keratoses
Basal Cell Skin Cancer	Blistering Sunburns	Dry Skin
Eczema	Flaking or Itchy Scalp	Hay Fever/Allergies
Melanoma	Poison Oak	Precancerous Moles
Psoriasis	Squamous Cell Skin Cancer	

Other _____

_____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes which relative(s)? _____

Any other family history: _____

Medications:

_____

_____

_____

Allergies to Medications: (please list and state the reaction)

_____

_____

_____

Patient Name _____ **Date of Birth _____**

Review of systems: (check yes or no)

Symptom	**Yes**	**No**
Allergy to Adhesive		
Allery to Topical Antibiotic Ointments		
Allergy to Lidocaine		
Allergy Latex		
Blood Thinners		
Problems with Bleeding		
History of Melanoma		

Have you received any of these vaccines? (yes or no) **FLU_____ Pneumonia _____**

Tobacco use	**Alcohol use**
○ Never ○ Former ○ Current	○ Never ○ Sometimes ○ Daily

COSMENTIC SERVICES QUESTIONNAIRE

○ COOLSCULPTING ○ BOTOX	○ PHOTO FACIALS ○ FILLERS