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

Patient DOB: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I do NOT wish to be contacted for promotional material

Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

Acne O Yes O No

Asthma O Yes O No

Atypical Moles O Yes O No

Cancer, skin O Yes O No

Diabetes O Yes O No

Eczema O Yes O No

Excessive Sweating O Yes O No

Flushing O Yes O No

Glaucoma O Yes O No

Hair Loss O Yes O No

Hay Fever O Yes O No

Headaches O Yes O No

Heart Disease/Attack O Yes O No

Hepatitis B O Yes O No

Hepatitis C O Yes O No

Herpes Simplex O Yes O No

High Blood Pressure O Yes O No

HIV/AIDS O Yes O No

Itching O Yes O No

Joint Aches O Yes O No

Kidney Disease O Yes O No

Lupus O Yes O No

Melanoma O Yes O No

Psoriasis O Yes O No

Thyroid Disease O Yes O No

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Has anyone in your immediate family

(parents, grandparents, siblings) had:

O Allergies O Eczema O Melanoma

O Non-Melanoma Skin Cancer

**PEDIATRIC PATIENTS** (UNDER 19Y/O)

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY**

Do you need to take antibiotics prior to any surgical and/or dental work? O Yes O No

**SKIN HISTORY**

Do you have a problem with skin or wound healing? O Yes O No

Do you develop keloids or thick scars after surgery? O Yes O No

Do you bleed easily? O Yes O No

Regular tanning bed usage, past or present?

O Yes O No

Any blistering sunburns past or present? O Yes O No

**WOMEN ONLY**

Irregular periods O Yes O No

Trying to get pregnant O Yes O No

Birth Control O Yes O No

Currently Pregnant/Nursing O Yes O No

**SOCIAL HISTORY**

Do you smoke? O Yes O No

Do you drink alcohol? O Yes O No

**GENERAL**

Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication allergies O Yes O No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_\_

Patient's Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_\_\_Self \_\_\_\_\_\_\_Spouse \_\_\_\_\_\_Child \_\_\_\_\_\_Other

Insured's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_

Insured's Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_

Insured's Home#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured's Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay(if not on card, put $0): \_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay(if not on card, put $0):\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EScripts ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIN # \_\_\_\_\_\_\_\_\_\_ PCN # \_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits and any/all medical benefits to Medical & Aesthetic Dermatology.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

**Patient's Signature Date Date**

**(Parent or Guardian of Patient Is a Minor)**

**PATIENT ACKNOWLEDGMENT OF OFFICE POLICIES**

**Insurance:**  I authorize this practice to submit a claim and, if needed, medical documentation to my insurance company, attorney or other financially responsible entity on my behalf.  I agree to provide accurate information at the time of EACH visit.  If inaccurate, inactive or no information is provided at the time of service I agree to pay the full balance of the account for the services provided.  I understand I am financially responsible for any amounts not covered by my insurance including but not limited to co-pays, coinsurances and or deductibles.  
**Referrals**: I understand that I am responsible to provide a referral from another physician if one is required by my insurance to be seen by this practice.  If a claim is denied by my insurance company because a referral was not provided at the time of service I agree to be financially responsible to for the full balance for the services provided.  Note: If you do not know if a referral is required please call your insurance.  The name of the practice is Medical and Aesthetic Dermatology and the NPI# is 1720367227.  
**Delinquent balances**:  An account is considered delinquent if an invalid mailing address is provided and/or the age of the balance reaches 90 or more days after the balance becomes the patient’s responsibility.  I understand and agree to be financially responsible for any additional charges or fees associated with delinquent balances.  Unpaid or delinquent balances may be subject to a $5.00 statement service fee and may be turned over to an outside collections agency and/or lawyer.  If turned over to an outside collections agency I agree to pay an additional fee of 33.3% of the total balance sent to the collections agency.  If sent to a lawyer I agree to pay an additional fee of 35% of the balance sent to the lawyer plus any additional legal fees incurred in collection of the balance. Returned checks will be subject to $35.00 fee.  
**Cancellation/No Show Policy**:  I agree to notify the practice at least 24 hours in advance of a scheduled appointment in order to cancel or reschedule the appointment.  I agree that if I do not notify the practice 24 hours in advance or I fail to arrive for an appointment by the scheduled time I may be responsible for a $50 fee for medical visits and/or a $100 fee for cosmetic or surgical appointments. The practice holds the right to discharge a patient after three consecutive no show or cancelled appointments.

**Cosmetic Consultation Policy:** I understand that Cosmetic Consultations are charged a fee of $200.00 per consultation. I also acknowledge that if I come in for a treatment and the appointment is changed to a consultation, I am still responsible for the consultation fee.  
**Maryland Law** (Section 18-338.3 et. seq.):  I agree that if, during the course of care, a health provider/worker may be directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B, C or AIDS, for the protection and wellbeing of the health care provider/worker, it is important that a test be made on my blood without charge to me to determine whether I am carrying the viruses and that under Maryland law I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider/worker. I also understand that health care providers/workers are deemed to consent to tests and the release of the results to me, should I be similarly exposed.

I agree to the terms of this agreement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Signature of patient or responsible party)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

• Protected health information may be disclosed or used for treatment, payment or health care operations

• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice

• The Practice reserves the right to change the Notice of Privacy Policies

• The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions

• The patient may revoke this Consent in writing at any time and all future disclosures will then cease

• The Practice may condition treatment upon the execution of this Consent.

**Who else may we discuss your Personal Medical Information with:**

* Parent (not applicable if minor child): Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Spouse: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Valid Until (If blank 3 years is assumed): Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**\**By signing your name below, you agree that this is valid as your signature.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature (Parent or Guardian if Patient is a Minor)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient (If Other Than Patient):**

**\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Date**