



DERMATOLOGY | AESTHETICS

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

SSN: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ City/State/Zip: _____

Primary Phone: _____ ☐ Mobile ☐ Home ☐ Work

Secondary Phone: _____ ☐ Mobile ☐ Home ☐ Work

Email: _____

Emergency Contact: _____ **Phone Number:** _____

Relationship: _____

Primary Physician: _____ Phone: _____

Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone: _____

Address: _____

ID Number: _____ Group Number: _____

PRIMARY INSURED (if different from patient)

Name: _____ Date of Birth: _____

Relationship: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____

Primary Phone: _____ Secondary Phone: _____

ADDITIONAL INSURANCE (if applicable)

Secondary Insurance Company: _____ Phone: _____

Address: _____

ID Number: _____ Group Number: _____

Subscriber Name: _____ Date of Birth: _____

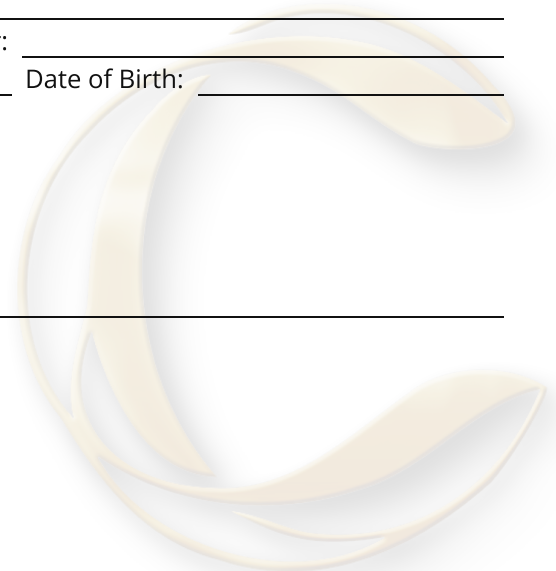
Relationship to patient: _____

Do you have a health care proxy?

☐ Yes ☐ No

If so, what is their name and date of birth? _____

Do you have a living will? _____





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Medical History

Surgical History

Do you have a history of the following skin conditions? (please check all that apply)

- ☐ Basal Cell Carcinoma
- ☐ Melanoma
- ☐ Precancerous moles
- ☐ Squamous Cell Carcinoma
- ☐ Other (please specify): _____

Do you use sunscreen daily? ☐ Yes ☐ No If yes, what SPF? _____

Do you use tanning beds? ☐ Yes ☐ No

Does anyone in your family have a history of melanoma? ☐ Yes ☐ No

If yes, which relative? _____

Medications

(Please list all medications you take, including vitamins, supplements, herbal remedies, and prescription or over-the-counter drugs.) Please include the dosage:

Food and Drug Allergies, including lidocaine and latex (please specify reactions):

Preferred Pharmacy and Location:



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Vaccines (for patients ages 9–13):

Has the patient received the meningococcal vaccine? If yes, when? _____

Has the patient received the Tdap vaccine? If yes, when? _____

Has the patient received at least two doses of the HPV vaccine? If yes, when? _____

Tobacco use (please check what applies):

☐ Never smoked ☐ Current smoker ☐ Former smoker

If current smoker, do you smoke daily? ☐ Yes ☐ No

Years smoking: _____

Alcohol use:

☐ Daily ☐ Weekly ☐ Never

Drug use:

Do you currently use any illicit drugs? _____

If so, please list them: _____

OPTIONAL AUTHORIZATIONS

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION:

I authorize Choice Dermatology to disclose my medical information to the following designated individuals:

Name: _____ Name: _____

Name: _____ Name: _____

COMMUNICATION CONSENT

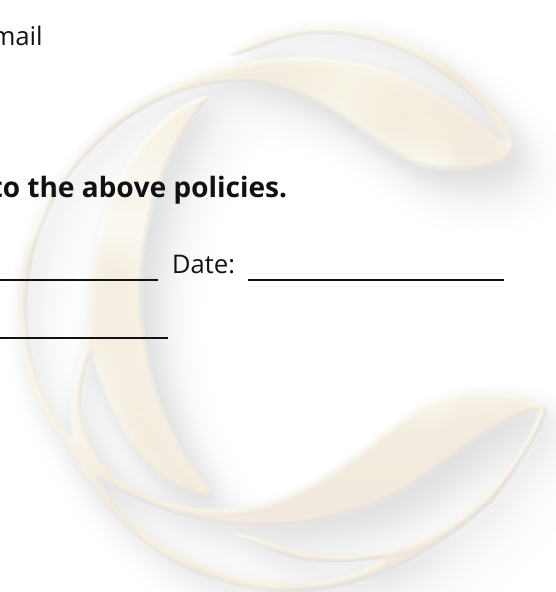
I consent to be contacted regarding appointments, results, and administrative communications.

Preferred method of communication: ☐ Phone ☐ Text ☐ Email

By signing below, I acknowledge and agree to the above policies.

Signature of Patient or Legal Guardian: _____ Date: _____

Printed Name: _____





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ACKNOWLEDGEMENT OF PRIVACY PRACTICES, ELECTRONIC ACCESS, AND OFFICE PROCEDURES

A scanned copy of this authorization shall be considered as valid as the original. This authorization may be revoked by me in writing at any time.

1. PRIVACY PRACTICES AND RELEASE OF MY PROTECTED HEALTH INFORMATION

I acknowledge that I have received a copy of Choice Dermatology LLC's Notice of Privacy Practices.

I understand that I may refuse to sign this acknowledgment.

I authorize the physician to release any information acquired in the course of my examination or treatment to my referring physician, billing staff and/or to my insurance carrier, as necessary to determine benefits and process claims.

2. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby assign payment directly to the physician for surgical and/or medical benefits, if any, otherwise payable to me for services rendered, but not to exceed my indebtedness to the physician for those services. I understand that I am financially responsible for all charges not covered by insurance.

3. PATIENT RIGHTS

Patients have the right to respectful, considerate, and confidential care, to be fully informed about their condition and treatment options, and to make decisions regarding their care, including the right to accept or refuse treatment.

4. CANCELLATION POLICY

A deposit is required at the time of booking:

- Services under \$400: \$50 deposit
- Services \$400 and above: \$100 deposit

A valid credit card must be kept on file.

If an appointment is canceled or rescheduled within 48 hours of the scheduled time, the deposit will be forfeited.

If an appointment is canceled, rescheduled within 24 hours, or in the event of a no-show:

- Services under \$400: 50% of the service price will be charged (deposit applied)
- Services \$400 and above: a total cancellation fee of \$300 will be charged (deposit applied)

5. INSURANCE VERIFICATION

It is your responsibility to provide up-to-date insurance information and to notify us of any changes in your coverage. You are responsible for all charges incurred. Failure to provide accurate insurance information that results in denial of claims will result in charges to your account, including a \$25 administrative fee for inactive or terminated insurance.

6. COLLECTIONS

If you fail to make any payment due to Choice Dermatology, we reserve the right to refer your account to a third-party collection agency. You will be responsible for all costs associated with collections, including a \$35 administrative fee.

7. ELECTRONIC MEDICAL RECORD ACCESS

I understand that I will be assigned access to an electronic medical record portal. Login information will be provided via email or printed documentation.

8. REFERRALS

Many insurance carriers require a referral from your Primary Care Physician. It is your responsibility to obtain any required referral prior to your visit.

By signing below, I acknowledge and agree to the above policies.

Signature of Patient or Legal Guardian: _____ Date: _____

Printed Name: _____

