ATLANTIC DERMATOLOGY ASSOCIATES, P.A.
PATIENT INFORMATION

Last Name____________________ First_____________________ Middle____________
Sex M [ ] F [ ] Marital Status S [ ] M [ ] D [ ] W [ ]
Birth Date ____________________ Social Security Number _______________________
Mailing Address ____
City__________________ State/Zip________________ Home Number ( ) ________
Employer ____ Work Number ( ) ________
If you would like to receive our newsletters and specials:
Email____

NEXT OF KIN
(IN CASE OF EMERGENCY)

Last Name____________________ First_____________________ Middle____________
Birth Date ____________________ SSN ______________ Relation ________________
Address ____ Home Number ( ) ________
Employer ____ Work Number ( ) ________

PRIMARY INSURANCE
Policy Name ___________________________
Insured's Name _________________________
DOB ___________ Relation_____________

SECONDARY INSURANCE
Policy Name ____________________
Insured's Name _________________
DOB ________ Relation __________

I authorize the release of medical and personal information which may include but is not limited to; processing of medical claims and referring to other physicians. I also authorize payment of medical benefits to the physician.

Signature _______________________________ Date ____________________

Payment is required for all services at the time they are rendered, this may include but not be limited to a co-payment, co-insurance, or your bill in full if your insurance is one we don't file.

Your signature below signifies your understanding and willingness to comply with this policy.

I agree to indemnify, defend and hold Atlantic Dermatology Associates, P.A. harmless from any loss, damages, costs, or expenses in connection with false insurance information provided by patient.

Signature _________________________________ Date ________________________

Method of Payment: Cash ________ Check ________ Credit Card _______

<u>Office Policies</u>

<u>APPOINTMENTS</u>: Patients are seen by appointment. For urgent and acute situations we often schedule "work-in" appointments. Work in appointments are made to address one acute problem only so that patients with scheduled appointments are not kept waiting. Except in emergencies, patients with scheduled appointments will be seen before "work-in" patients.

We work very hard to keep our appointment schedule. However, because we see emergencies in the office there will inevitably be delays. We apologize in advance.

We will call to confirm most appointments two days in advance. If you are more than 15 minutes late by our clock, you will be asked to reschedule your appointment. Cancellations must be made 24 hours prior to your appointment. **We charge $25.00 for missed appointments.**

<u>SOCIAL SECURITY NUMBERS</u>: We handle patient's social security numbers and personal information in a confidential manner but we may release personal and medical information to another doctor's office in the event of a referral. We use social security numbers for insurance and billing purposes at Atlantic Dermatology Associates. This required information we ask from each of our patients.

<u>INSURANCE</u>: Insurance is a contract between you and your insurance company. We are actually not involved in that contract, therefore, we cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, labs, or other charges. Currently we file claims for BCBS plans that can be filed through NC, United Health Care, Medcost, Cigna, NCTA, Aetna, Medicare and Tricare. For all other insurance, we will provide you with the required information so you can file your claim with your insurance company. If we are non-participating with your insurance plan, then you will be responsible for payment at the time the services are provided. If you have an insurance that has a co-payment, our office policy is to collect this before services are rendered. Also, if there is any change in your insurance carrier, it is your responsibility to inform us prior to your appointment.

You must have a current insurance card for us to file your insurance. If you do not have your card at the time of your appointment, you will be expected to pay in full if you wish to be seen, or your appointment can be rescheduled.

<u>MINORS</u>: All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave children unattended in the waiting area.

<u>PAYMENT</u>: Payment is due from each patient at the time of service. We accept cash, check, VISA, and MasterCard. We do not bill parents or guardians not present in the office at the time of their appointment. Patients with co-pays, deductibles, percentages, etc are expected to pay at the time of their appointment. Simply put, payment of any portion of your bill that you are responsible for "out of pocket" is expected at the time of your appointment. There will be a $35.00 service fee on all returned checks.

<u>PHONE CALLS</u>: You may need to contact the office with questions. Most call may not be returned for up to several hours. Please provide a return phone number that can be reached for several hours, or provide additional phone numbers. In an emergency dial 911 first.

<u>AFTER HOUR PROBLEMS</u>: We are on call 24 hours a day, available only for urgent issues that cannot wait for the office to open the next business day. To contact us, please call the office number.

<u>ACKNOWLEDGEMENT</u>: I have read, understand, and agree to follow the above office policies.

Patient/Guardian signature___________________________ Date_______________

Printed name of patient_______________________________

Printed name of guardian and
relationship to patient if applicable____

History and Intake Form

Past Medical History:

Anxiety	Y/N	End Stage Renal Disease	Y/N	Leukemia	Y/N
Arthritis	Y/N	GERD	Y/N	Lung Cancer	Y/N
Asthma	Y/N	Hearing Loss	Y/N	Lymphoma	Y/N
Atrial fibrillation	Y/N	Hepatitis	Y/N	Prostate Cancer	Y/N
BPH	Y/N	Hypertension	Y/N	Radiation Treatment	Y/N
Breast Cancer	Y/N	HIV/AIDS	Y/N	Seizures	Y/N
Colon Cancer	Y/N	High cholesterol	Y/N	Stroke	Y/N
COPD	Y/N	Hyperthyroidism	Y/N	Bone Marrow Transplantation	Y/N
Coronary Artery Disease	Y/N	Hypothyroidism	Y/N		
Depression	Y/N				
Diabetes	Y/N				

Other ____

Past Surgical History:

Appendix Removed	Y/N	Biological Valve Replacement	Y/N	Prostate Removed TURP	Y/N
Bladder Removed	Y/N	Heart Transplant	Y/N	Prostate Cancer	Y/N
Mastectomy (Right, Left, Bilateral)	Y/N	Replacement, Knee (Right, Left, Bilateral)	Y/N	Prostate Biopsy	Y/N
Lumpectomy (Right, Left, Bilateral)	Y/N	Replacement, Hip (Right, Left, Bilateral)	Y/N	Skin Biopsy	Y/N
Breast Biopsy (Right, Left, Bilateral)	Y/N	Kidney Biopsy	Y/N	Basal Cell Cancer Surgery	Y/N
Breast Reduction	Y/N	Kidney Removed (Right, Left)	Y/N	Squamous Cell Cancer Surgery	Y/N
Breast Implants	Y/N	Kidney Stone Removal	Y/N	Melanoma Surgery	Y/N
Colectomy	Y/N	Kidney Transplant	Y/N	Spleen Removed	Y/N
Colon Cancer	Y/N	Endometriosis	Y/N	Testicles Removed (Right, Left, Bilateral)	Y/N
Resection Colectomy:	Y/N	Ovarian Cyst	Y/N	Hysterectomy	Y/N
Diverticulitis Irritable Bowel Disease	Y/N	Ovaries Removed	Y/N	Fibroids	Y/N
Gallbladder Remove	Y/N	Ovarian Cancer	Y/N	Uterine Cancer	Y/N
Coronary Artery Bypass	Y/N			Other: ______________	
Angioplasty (PTCA)	Y/N				
Mechanical Valve Replacement	Y/N				

Skin Disease History:

Acne	Y/N	Dry Skin	Y/N	Poison Ivy	Y/N
Actinic Keratoses	Y/N	Eczema	Y/N	Precancerous Moles	Y/N
Asthma	Y/N	Flaking or Itchy Scalp	Y/N	Psoriasis	Y/N
Basal Cell Skin Cancer	Y/N	Hay Fever Or Allergies	Y/N	Squamous Cell Skin Cancer	Y/N
Blistering Sunburns	Y/N	Melanoma	Y/N	Other: ________________	

Name: ____ Today's Date: __________________

DOB: __/___/____ Age: ________ Who is your Family Physician?____________________________

How were you referred to Atlantic Dermatology Associates, PA?______________________________

Referring Physicians & Possibly other physicians will be updated of your care unless you circle: Do Not Update

Do you faint easy with procedures? Y/N

Do you wear Sunscreen? Y/N If yes, what SPF? __________

Do you tan in a tanning salon? Y/N

Do you have a family member with Melanoma? Y/N

If yes, which relative(s)? ____

Medications: (Please enter all current medications)

____

____

____

Allergies: (Please enter all allergies)

____

____

____

Social History:

Sexually active with one partner Y/N

More than one partner? Y/N

Currently Smokes Y/N

Has smoked in the past Y/N

Drug Use Y/N

Review of Systems: Are you currently experiencing any of the following?

***If yes to any of these symptoms, please follow up with your primary care provider as we only treat dermatological conditions.*

Pacemaker Y/N

Defibrillator Y/N

Artificial Joints Y/N
Within past 2 yrs

Artificial heart Valve Y/N

Meds Required Y/N
Prior To procedure

Adhesive allergy Y/N

Allergy to Y/N
topical antibiotics

Blood thinners Y/N

Pregnant or planning Pregnancy Y/N

Allergy to Y/N
Lidocaine

Rapid heartbeat to
epinephrine Y/N

Yeast infections on
Antibiotics Y/N

GI upset with
Antibiotics Y/N

Bleeding problems Y/N

Problems healing Y/N

Scarring Y/N
(Keloid/ Hypertrophic)

Immunosuppression Y/N

Changing Mole Y/N

Rash Y/N

Abdominal Pain Y/N

Anxiety Y/N

Bloody Stool Y/N

Bloody Urine Y/N

Blurry Vision Y/N

Chest Pain Y/N

Cough Y/N

Depression Y/N

Fever or chills Y/N

Headaches Y/N

Hay Fever Y/N

Joint aches Y/N

Muscle weakness Y/N

Neck stiffness Y/N

Night sweats Y/N

Seizures Y/N

Shortness of breath Y/N

Sore throat Y/N

Thyroid problems Y/N

Unintentional Weight loss Y/N

Wheezing Y/N

Are you interested in cosmetic or Esthetic Services? Y/N What bothers you? ______________________

________________________ __/__/__ ________________________ __/__/__

Patient Signature (or Guardian) Date Physician/Nurse Date

Pharmacy of choice: ____

NAME:_______________________________ DATE:__________________________

COSMETIC SKIN CARE SERVICES

Dear Patient:

New technologies have expanded the range of products and procedures available to enhance the appearance of your skin. To help us provide you with the services you desire and the best treatment possible, we would like you to answer a few questions regarding your skin, hair and nail needs. So please take a few minutes to give us this important information.

Thank You,

The following is a list of the various cosmetic services we provide to our patients. Please indicate the procedures in which you may be interested, or for which you would like more information from the doctor or our nurses.

- "AGE SPOT" REMOVAL
- BOTOX THERAPY-for crows feet and forehead lines
- COSMETIC MAKEOVER/COSMETIC PRODUCTS/SUNSCREENS
- FACIAL PEELS-for lines and spots
- INDIVIDUALIZED TOTAL SKIN CARE REGIMENS
- LASER HAIR REMOVAL
- LASER REMOVAL OF FACIAL VEINS, SUN OR AGE SPOTS
- MICRODERMABRASION-for smoothing facial lines and evening skin color
- ALPHA HYDROXY ACID PRODUCTS-topical therapy anti-aging/wrinkles
- SCLEROTHERAPY-leg "spider" vein removal
- TATTOO REMOVAL
- THERAPY FOR BRUISED SKIN/DARK EYE CIRCLES
- JUVEDERM AND RESTYLANE FILLERS-for nasal folds and lip and mouth lines

ADDITIONAL COMMENTS:
____
____
____
____

Revised 8/29/07