How did you hear about us? _____

Cosmetic Medical History

Name _____ Date of Birth __/__/__ Today's Date__/__/____

Reason for today's visit: _____

Please circle your cosmetic concerns:

Sun spots / Age Spots	Wrinkles	Birthmarks- Brown/Red
Spider veins Face	Telangiectasia	Red spots- cherry angiomas
Hyperpigmentation	Rosacea	Leg Veins
Acne Scars	Large pores	Actinic Keratoses / Precancers
Surgical scars	Hypertrophic scars	Laser Hair removal
Sagging Skin	Lines around mouth/eyes	Discuss Skin care regimen

Previous Cosmetic Treatments/Surgeries*_____

_____

What current skin care products are you using? _____
Are you allergic to any medications, including skin related allergies? □ Yes □ No
If yes, which medication? _____
Have you ever had an allergic reaction to anesthesia/injections? □ Yes □ No
List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, herbals):

_____

_____

Are you pregnant, nursing, or planning a pregnancy soon? □Yes □ No _____
Have you ever had skin cancer? □Yes □ No If yes,_____
Has anyone in your family had skin cancer? □Yes □No
Do you have a history of any specific skin diseases? □ Yes □ No If yes,_____
Do you have problems with healing? □ Yes □ No
Do you develop keloids (scars) after surgery? □ Yes □ No If yes,_____
Do you bleed easily? □ Yes □ No
Do you develop skin rashes in reaction to □Medications □ Food □Environment □ Bandages □ Topical Neosporin □ Other _

_____

Do you smoke? □Yes □ No If yes, how much: _____
□Current Smoker □Former Smoker □Never Smoked
Do you drink? □Yes □ No If yes, _____ drinks per day
Have you had or have been exposed to HIV (AIDS), Hepatitis A, B, or C? □ Yes □ No
If yes, _____

Have you ever had cold sores or fever blisters? □ Yes □ No

When was last breakout? _____

What is your occupation? _____Hobbies? _____

Mark your skin type (when exposed to the sun for about 1 hour with no protection):

Skin Type	Skin Color	Characteristics
I	White; very fair; red or blond hair; blue eyes; freckles	Always burns, never tans
II	White; fair; red or blond hair; blue, hazel, or green eyes	Usually burns, tans with difficulty
III	Cream white; fair with any eye or hair color; very common	Sometimes mild burn, gradually tans
IV	Brown; typical Mediterranean Caucasian skin	Rarely burns, tans with ease
V	Dark Brown; mid-eastern skin types	very rarely burns, tans very easily
VI	Black	Never burns, tans very easily

When did you last get a tan? _____

Do you wear a sunscreen daily? □ Yes □ No

Do you use chemical (sunless) sun tanning lotions? □ Yes □ No

Do you have any upcoming social events? □ Yes □ No If yes,_____

Patient Signature _____ Date _____

Reviewed by _____ Date _____

Dermatology Specialists

REGISTRATION SHEET – PLEASE COMPLETE

Last name _____
First name_____MI___
(As printed on Insurance card if applicable)

Primary Care Physician _____
Telephone # of PCP_____
Referring Provider_____
Date of birth_____

Sex: M or F
Marital status: S/ M/ W/ Partner
Social Security #_____
Employer name_____
Race/Ethnicity _____
Preferred Language _____
How did you hear about us?
Other Patient _____ Referral _____ Ad_____
Emergency contact_____
Phone #: _____
Relationship to Patient:_____

Address line 1_____
Address line 2_____
City_____
State _____ Zip_____
Home phone_____
Cell phone_____
Work phone_____
*Preferred pharmacy*_____

Email address_____
(for DSB purposes only will not be shared)

Primary Insured Responsible Party (Fill out this portion if different from Self)

Name: Self / Other Named _____MI: _____ DOB_____
Address:_____City_____State_____Zip_____
Telephone #:_____Relationship to Pt_____
Subscriber # _____ Group #:_____

INSURED RESPONSIBILITY: It is understood that services rendered by DS are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of DS to collect from the insurance company. We do this as a service to our patients.

PATIENTS: I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or is pre-existing, that I am responsible to promptly pay the balance in full.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All returned checks (NSF, Account Closed, Refer to Maker, or Uncollected Funds) are subject to a $40 service charge and cost of collection fee. In consideration of any services rendered by DS, or associated health care provider, I agree to be responsible for the payment of all services notwithstanding any insurance coverage I may have. If it is necessary for DS to employ anyone, including collection agencies and attorneys, to collect such payments, then I shall be responsible to pay reasonable fees and costs, as well as a $25 surcharge, in addition to said payment.

I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to any referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to DS.

Do we have your permission to:
1) Is it ok to leave a detailed message? Yes ___ No ___ Preferred # Home _____ Cell_____
2) Discuss your medical condition with any member of your family? If yes Whom? _____Relationship:_____
Whom? _____Relationship:_____

In signing this document, I am attesting that I have read the above and that I have had all of my questions answered to my satisfaction.

_____ _____
PATIENT SIGNATURE/LEGAL GUARDIAN DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Insurance Authorization And Assignment, I hereby authorize Dermatology Specialists to furnish information to insurance carriers concerning my diagnosis and treatments and I hereby assign to the physicians all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance and all collections costs should this account be assigned for collection. I accept and understand the responsibility of notifying DS of any requirement by my insurance company of pre-authorization prior to any surgical procedure. I understand that if I fail to get a referral, if necessary, I will be responsible for the charges.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

FOR OFFICE USE ONLY

This consent was signed in front of _____

DERMATOLOGY SPECIALISTS
SURGICAL · MEDICAL · COSMETIC

T 303-442-6647 F 303-442-2696 WWW.DSDERM.COM

Conscientious care delivered, together

Financial Policy for Self-Pay Patients

Thank you for choosing Dermatology Specialists! Our practice firmly believes that a good physician/patient relationship is based upon good understanding and clear communication. We are committed to the success of your medical care and well-being. Please understand that payment for your financial responsibility is necessary for us to be able to continue to serve you and our community. To help avoid misunderstandings, our financial policy is in writing below.

All self-pay patients are required to read and sign this agreement prior to any service being provided. Patient agrees to pay in full on each day of service.

Patient understands that the rates quoted are for un-insured patients only that pay at the time of service and that the resulting bill cannot be presented to any insurance provider for re-imbursement or to apply against deductibles. These bills will not be coded for that purpose and patient agrees not to do so or request new billing for this purpose.

All biopsies and mole removals performed in our office may be submitted for pathology for analysis. Some of the tissue may be processed in our in-office lab or sent to an outside pathology lab. Tests and treatments performed in our office are necessary to ensure proper diagnosis and care for our patients. There may be additional charges for these labs or tests. Patient understands that if there are additional charges they will be responsible for paying these directly to those providers and billing will not be processed through Dermatology Specialists.

Our practice accepts cash, checks, money orders, Visa, MasterCard, Discover and American Express as forms of payment. Returned checks will be assessed a fee of $40. Please note that delinquent accounts will be subject to the services and fees of a collection agency.

I have read and fully understand the Financial Policy for Dermatology Specialists. I agree if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charges by the collection agency for the cost of collections.

Patient/Guardian Signature: _____ Date: _____

Printed Patient Name/Guardian: _____ DOB: _____