Anne Arundel DERMATOLOGY
*and Affiliate Practices*

**Patient Name:** _____

**Date of Birth:** _____

# General Consent/Agreement to Outpatient Services

This form applies to all Anne Arundel Dermatology practice sites. This form must be completed by all new patients and then, at least annually or when the patient's insurance changes.

1. **CONSENT TO TREATMENT:** I consent to receive medical and/or cosmetic health care services provided by Anne Arundel Dermatology (AADerm") entities. I understand that such services may include but are not limited to examination and treatment of skin disorders, performing cryosurgery, shave biopsies, punch biopsies or other minimally invasive testing on lesions, and sending specimens to a pathology or other lab for diagnosis. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

2. **PAYMENT FOR SERVICES**: I understand that AADerm may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Anne Arundel Dermatology . If I should receive the payments, I understand that I will be responsible for paying AADerm. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. I understand that AADerm will hold me responsible in any one of the following situations

    a. When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
    b. When I choose not to use my health plan and agree to pay for services myself. (Use Do Not Bill Insurance Form).
    c. When my health plan does not participate with AADerm for the services I want or need and I agree to pay for my care myself.
    d. When I receive services that are not covered under my health plan including cosmetic services.

    If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have AADerm act on my behalf to obtain my benefits when AADerm asks to do so. I also agree that AADerm can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

    I understand if I do not show up for a scheduled visit and do not notify the office, I will pay a NO SHOW fee of $50.00. If I cancel my appointment in advance or on the day I am scheduled, my appointment will be rescheduled without a fee. If I repeatedly cancel, a cancellation fee may be charged.

3. **CONSENT TO PHOTOGRAPH:** I understand photographs, videotapes, digital and/or other images may be made/recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.

4. **ELECTRONIC PRESCRIBING**: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to AADerm for the purpose of continued treatment.

5. **MY PERSONAL BELONGINGS:** I understand that I am responsible for my personal belongings and valuables.

6. **RELEASE OF INFORMATION:** I authorize AADerm practice site(s) to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information from or regarding prior encounter(s) at other AADerm practice locations may be made available to subsequent AADerm-affiliated sites to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
    If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

**DISCLOSURES to FAMILY and FRIENDS:** I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

| | Name | Relationship | Contact Number |
|---|---|---|---|
| 1: | | | |
| 2: | | | |
| 3: | | | |

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

7. **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT:** I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for AADerm and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of AADerm. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

   You may be contacted via voicemail, text, or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide newsletters and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications unless I request a change in writing.

   Home Phone: _____. Cell Phone: _____

   Authorized email address: _____.

   **OR**

   _____ (Initials) I decline to receive communication via text.

   _____ (Initials) I decline to receive communication via email.

**Revocation**

**I hereby revoke my request for future communications via email and/or text.**

__I hereby revoke my request to receive any future appointment reminders, feedback, marketing and general health via text

__I hereby revoke my request to receive any future appointment reminders, feedback, marketing, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: Time:

8. **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received/reviewed AADerm's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

**I agree to the items as outlined in the Agreement.**

Name (Print): _____ Signature: _____ Date: _____

Relationship to Patient (Self/Parent/Personal Representative): _____

Anne Arundel DERMATOLOGY
*and Affiliate Practices*

| PATIENT ACCOUNT NO. |
|---|
| |

# Patient Information Record
## Please PRINT All Information

**DATE**

## PATIENT INFORMATION

| PATIENT'S NAME (LAST, FIRST, MI) | | | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP |
| HOME PHONE | WORK PHONE | CELL or ALTERNATE PHONE | |
| EMAIL ADDRESS: | | | |

| SEX | MARTIAL STATUS | AGE | DATE OF BIRTH | HAVE YOU EVER BEEN A PATIENT IN THIS OFFICE BEFORE |
|---|---|---|---|---|
| ☐ Male<br>☐ Female | ☐ Married ☐ Single ☐ Legally Separated<br>☐ Divorced ☐ Unknown ☐ Widowed | | | ☐ Yes ☐ No<br>IF YES, WHEN? |

| OCCUPATION | EMPLOYER |
|---|---|
| WORK ADDRESS | |
| SPOUSES NAME (LAST, FIRST, MI) | SPOUSES DATE OF BIRTH |

| STUDENT STATUS<br>Full Time Part Time Not a Student | PRIMARY CARE PHYSICIAN | ADDRESS | PHONE |
|---|---|---|---|

## PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

| NAME | | RELATIONSHIP |
|---|---|---|
| ADDRESS | | |
| OCCUPATION | EMPLOYER | PHONE |
| ADDRESS | | WORK PHONE |

## POLICY HOLDER INFORMATION

*PRIMARY INSURANCE INFORMATION*

| INSURANCE COMPANY | NAME OF POLICY HOLDER | |
|---|---|---|
| GROUP # | CERTIFICATE/POLICY/ ID# | POLICY HOLDERS DATE OF BIRTH |
| MEDICARE # | MEDICAID # | POLICY HOLDER'S SOCIAL SECURITY NUMBER |

*SECONDARY INSURANCE INFORMATION*

| INSURANCE COMPANY | NAME OF POLICY HOLDER | POLICY HOLDER'S SOCIAL SECURITY NUMBER |
|---|---|---|
| GROUP # | CERTIFICATE / POLICY / ID # | POLICY HOLDERS DATE OF BIRTH |

**Assignment of Benefits:**

I hereby assign and authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/ or all commercial payors to make payments on my behalf directly to Anne Arundel Dermatology. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in place of the original.

Signed _____ Date _____

***A fee may be incurred for No Show and/or cancellation without required notice. Initial _____ Date _____ ***

How did you hear about Anne Arundel Dermatology, P.A. and Affiliate Practices

☐ Radio ☐ Insurance Website ☐ Magazine ☐ Google Search ☐ Social Media ☐ Family/Friend ☐ Physician Referral ☐ Other: _____

Anne Arundel DERMATOLOGY
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**Cosmetic Financial Agreement & Policies**

**INTRODUCTION**

Cosmetic services are elective and are not covered by and are not able to be submitted to your health insurance company (this also includes HSA & FSA plans), thus you are considered a "Self-Pay" patient. Self-pay patients will be responsible for necessary charges associated with their service(s) rendered. The fees charged for this service(s) do not include any potential future costs for additional service(s) that is elected to have performed in order to optimize or complete the patient's desired outcome. Additional costs may occur should complications develop from the service. Subsequent service(s) that are performed with the intent of revision will also be the patient's responsibility.

All cosmetic service fees (i.e. Laser, Injectables, CoolSculpting, Skincare Retail products, and MedSpa Services) are due upon the time of treatment. In some cases, a deposit may be requested prior to scheduling specific treatments, and in those cases the remaining balance of that treatment is due prior to services being rendered (i.e. CoolSculpting).

All cosmetic self-pay patients will receive a cosmetic consultation prior to their cosmetic services being rendered. At that time fees, contraindications, pre and post care, side effects, and potential benefits will be reviewed. The provider reserves the right to refuse to perform procedures or treatments which are not appropriate for the patient in his/her professional judgement.

**PAYMENT POLICY**

At Anne Arundel Dermatology and Anne Arundel Dermatology Affiliate locations, cosmetic treatments are elective aesthetic procedures, these treatments and procedures cannot be billed to insurance. Payment for all treatments are due at the time of the treatment, and all packages must be paid in full prior to the first treatment being rendered. We do not offer financing or payment plans. For our patients' convenience, we do participate with all of *CareCredit's promotional plan options for purchases $200 and over. All treatments are final sale; there are no refunds or credit issued for any service, including, but not limited to; Laser treatment, IPL, Botox, Fillers, Microneedling, Microdermabrasion, Chemical Peels, Facials, Body Sculpting, CoolSculpting, and Skincare Retail products. We accept Cash, Personal checks, Visa, MasterCard, Discover, American Express, and *CareCredit. There will be a $25 service charge for each returned check.

When CareCredit is used to pay for cosmetic procedures; the following guidelines must be adhered to in order to process the patient transaction(s). The patient will need *2 forms of valid identification: One primary and One secondary. An Annne Arundel Dermatology or Anne Arundel Dermatology Affiliate employee must notate both valid ID types in the space provided in the shaded top portion of the CareCredit application. If the patient submitted the application online, an Anne Arundel Dermatology or Anne Arundel Dermatology Affiliate employee must notate the ID types on the signed printout of the online application. The employee must retain the signed application page (for 72 months), whether the application is Approved or Declined.*

*ID Requirements for Terminal Transactions, a Card must be Present and Swiped. When swiping the CareCredit Private Label Card or Rewards Mastercard to process a transaction, the card serves as the primary identification, and additional ID does not need to be notated. If Card is Present, but cannot be swiped then 1) Check one form of Primary ID from the approved list and 2) Verify name on ID matches the name shown on the card then 3) Capture ID information on the bottom of the receipt. If the card is not Present/Available Call CareCredit Provider Services at 800-859-9975 and verify names on the account and the available credit.*

-Transaction Restrictions –

- CareCredit can only be used and charged for services that have been completed or that will be completed within 30 days of the initial charge. This requirement does not apply to charges for orthodontic service or for custom products ordered by the patient/client.
- Accounts Receivable balances aged greater than 90 days may not be charged on CareCredit credit card.
- A NO REFUND policy, where no services/products were rendered, is not acceptable, except in the case of custom special order items, where the non refund-ability has been clearly disclosed to the cardholder.
- Any refunds processed for cardholders who originated a transaction with a CareCredit credit card must be refunded to the CareCredit credit card.
- As an important reminder about the CareCredit credit card, Anne Arundel Dermatology and Anne Arundel

Dermatology Affiliate locations cannot pass on the merchant and/or any other CareCredit fees to your patients/clients. This aligns with CareCredit Card Acceptance Agreement for Participating Professionals.

- If a cardholder desires to transact using their CareCredit credit card, the card must be accepted regardless of the transaction amount. For example: a) Transactions under $200 will be processed as Standard Account Terms transactions. b) Transactions of $200 or more will be processed on at least the 6 month Deferred Interest/No Interest if Paid in Full promotion.
- Consumers (regardless of channel (e.g. in-store, online, by phone) must be provided a copy of the sales receipt.

At most but not all, Anne Arundel Dermatology and Anne Arundel Dermatology Affiliate cosmetic offices, we participate in loyalty rewards programs such as Brilliant Distinctions through Allergan and Aspire Rewards through Galderma. We believe this is just another layer of customer services and patient appreciation that we can extend to you during your visit! When you purchase Botox, Juvaderm, Latisse, Restylane, Dysport, or CoolSculpting for example, and you are a participant with the loyalty rewards programs you can receive loyalty points which will accrue over time. The points may then be applied to future cosmetic procedures as outlined by the Vendor and AADerm parameters, in addition to any office discounts, events, or promotions being offered at the point of purchase. This is the only instance in which 2 promotional/discount opportunities can be combined. There are no further exceptions. The use of points and/or redemption can only be applied when a treatment is paid in full at the time of your service being rendered. We are only able to honor and redeem loyalty points, coupons, and discounts when the patients unique Vendor code has been provided to an Anne Arundel Dermatology or Anne Arundel Dermatology Affiliate employee at the point of sale. Loyalty coupons, and discount redemptions will not be redeemed retroactively. Loyalty coupons, and discount redemptions will not be redeemed by supplying proof of email notification, but only after supplying your unique Vendor code. The Brilliant Distinctions and Aspire Rewards points are non-refundable. The reward points will expire and we strongly encourage our patients to keep track of your points through either the Brilliant Distinctions App or Aspire Rewards website. When points are applied to a cosmetic treatment transaction, any office discounts, event pricing, and/or promotions will first be applied, then the rewards points will be applied secondarily; example: $300 for specified treatment, 10% off for Veteran's discount = $270 Balance, you are redeeming $50 BD points, so your balance owed is now $220.

All skincare retail product (both RX and non-RX) sales are final and monies paid are non-refundable. In case of documented allergic reaction or clearly defective product, exchanges can be made within 14 days of purchase for skin care product credit only. Must have original proof of purchase and exchange can only be made at original purchase location, per management approval.

*CareCredit is offered at select locations. Please check with your office location and with your provider at the time of consultation, and prior to services being rendered to confirm their participation with this payment option.

*Allergan Brilliant Distinctions and Galderma Aspire Rewards participation is offered at select locations. Please check with your office location and with your provider at the time of consultation, and prior to services being rendered to confirm their participation with this payment option.

-You will not receive a coded receipt for the service(s) rendered. Your check, or credit card slip is your receipt. If cash is paid, a cash receipt will be provided.

-The office will at no time, now or in the future, submit a claim to your insurance carrier, as the provider has deemed the service not medically necessary under the terms of this practice's contract with your carrier.

**CANCELLATION AND NO-SHOW POLICY**

As a courtesy to other patients, we request you arrive on time. If you to arrive more than 10 minutes late for your scheduled appointment, you may be asked to reschedule. Appointments canceled on the date of a scheduled visit represent a cost to the practice and a missed opportunity to see other patients who are waiting for a visit date.

-We require 24 hours' notice of cancellation. After three missed appointments, you will be charged a fee of $50.

-Reminders will be provided but are not guaranteed.

-The $50.00 fee will need to be paid in full prior to rescheduling your next appointment, and/or prior to being seen for treatment should your account have an outstanding balance.

-If you are a new patient, we ask that you arrive 30 minutes early for registration completion, so we can see you at your scheduled appointment time.

-A minimum of 24 hours' notice is required to cancel an appointment without incurring a cancellation fee of $50.00. The fee is not covered by your insurance plan. There is a separate CoolSculpting/Body Sculpting cancellation policy that governs CoolSculpting/Body Sculpting rescheduling.

**COOLSCULPTING/BODY SCULPTING POLICY; DEPOSIT, REFUND POLICY & TREATMENT OUTCOMES POLICY**

-A $500.00 deposit is required to secure your CoolSculpting/Body Sculpting appointment date and time with your treating provider. The remaining CoolSculpting/Body Sculpting balance will be due the day of your appointment prior to receiving your treatment. The $500.00 deposit gets applied to your remaining balance due, and the deposit serves as a reservation for the appropriate time needed to treat based on your consultation expectations.

-50% of your deposit ($250.00) is non-refundable if you miss your CoolSculpting treatment appointment or fail to provide at minimum 24 hours' notice to cancel the appointment to treat. (This fee goes towards Provider and Administrative costs associated with treatment schedule).

-Should you wish to reschedule your treatment, an additional pre-paid deposit of $250.00 will be required, and you must receive treatment within 90 days of your original, canceled treatment date. The additional $250.00 deposit gets applied to your remaining balance due.

-Any monies paid for CoolSculpting/Body Sculpting packages are non-refundable. If your provider decides it best not to complete your treatment package, it may be established that monies for unused cycles will remain on your account as a credit towards other services. *This determination will be made as needed and based on Office Manager's approval at the purchasing location. This is not a guarantee.

-In the event that a package or series of treatments has begun, these services will be considered to have been rendered even though the full series may not have been completed.

- We do not offer refunds on services rendered.

**GIFT CERTIFICATE AND GIFT CARD POLICY**

Gift certificates and gift cards purchased either at Anne Arundel Dermatology locations, Anne Arundel Dermatology Affiliate locations, as well as online are non-refundable. Gift certificates and gift cards cannot be redeemed for cash, and they cannot be redeemed for gratuities.

Gift cards are valid for four years after the date of purchase and AADerm will not impose fees or charges of any kind during that four-year period. Federal legislation stretches expiration protection to five years; however, consumers may be charged fees during this fifth year and any year thereafter.

Any terms or conditions concerning an expiration date or fee will be printed clearly in a visible place on the front or back of the certificate/card, on a sticker permanently affixed to the gift certificate/card, or on an envelope containing the gift certificate/card. Expiration date will be noted on the sticker or packaging. Typical fees include service charges, fees for inactivity, maintenance fees, and reload fees. Terms and conditions will not be charged after the issue of the gift certificate or gift card unless they benefit the cardholder.

**PRE-PAID TREATMENT, TREATMENT PACKAGE/SERIES POLICY; REFUND POLICY & TREATMENT OUTCOMES POLICY**

To deliver the best level of patient care and efficiency regarding packages and series offerings we strive for transparency and for clear expectations to be set with the policies below:

-All service packages and pre-paid treatments must be used within 1 year from the date of purchase or they will expire.

-In the event that a package or series of treatments has begun, these services will be considered to have been rendered even though the full series may not have been completed.

- We do not offer refunds on services rendered.

-At AADerm we offer treatments and product that are irrevocable. Therefore, we do not issue refunds or credits for any product or service that has been injected or used in your treatment including by not limited to (Botox, Juvederm, Kybella, Dysport, Restylane, and Jeuveau). Again, all sales are final. In consenting to be treated, it is important that our patients understand and accept this condition.

-Should you wish to discontinue your treatment in the midst of a series, credit for the pro-rated share of unused treatments at the discounted package price may be extended, and this may be used to purchase other treatments or products offered by AADerm. **This determination will be made as needed and based on Office Manager's approval at the purchasing location. This is not a guarantee.*

- Patients who have purchased our services from a Friends & Family event or Open House, agree that they understand and consent to the terms and conditions of that promotion, as the terms and conditions of that promotion will apply. Services that have already been rendered will not be redeemed again.

**NEW PATIENT/WALK-IN PURCHASE POLICY**

All New Patient paperwork must be completed, and a patient chart entered into our secure and HIPPA compliant EMR and practice management system before a transaction or purchase can be made. This may also require associated consent forms signed and reviewed by an Anne Arundel Dermatology or Anne Arundel Dermatology Affiliate provider. No exceptions will be made.

**ONLINE STORE PURCHASES**

All policies and criteria outlined in this agreement are applicable to any online store purchases made through either Anne Arundel Dermatology or Anne Arundel Dermatology Affiliate locations.

**TREATMENT OUTCOMES**

At Anne Arundel Dermatology and Anne Arundel Dermatology Affiliate locations we take great efforts to be honest in all of the interactions with you as our valued patient. Aesthetics is not an exact science, and patient outcomes vary from patient to patient, and results are based solely on your individual response to the treatment(s). As it is not possible to predict or guarantee results, any payments made are for treatments performed, not for the specific result desired.

***ADDITIONAL SITE SPECIFIC CONSIDERATIONS (HUNT VALLEY, MD)**

-50% Deposit is due upon scheduling your appointment. The balance will be due on date of service, prior to treatment.

-Ulthera/Thermage: 20% of the total fee is nonrefundable if the appointment is canceled with less than ONE WEEK of notice.

-Sculptra: Full deposit is required. Nonrefundable if the appointment is canceled with less than ONE WEEK of notice.

-Other procedures: 20% of the total fee is nonrefundable if the appointment is canceled with less ONE WEEK of notice.

*Additional site locations and/or offices may have additional considerations or policies that may not be indicated by this form. Please ask your site location if there are any of these instances.

Consent: My consent for the procedure(s) is strictly voluntary. My signature on this form authorizes Anne Arundel Dermatology to perform the procedure(s). I have read this informed consent form and certify that I understand the contents in full. My signature indicates that I am consenting to receive treatment(s) and have had the opportunity to ask questions about the procedure(s) and associated risk(s). I have been advised of the risks involved in such treatment(s) and alternative treatment(s), including no treatment at all. I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurance have been made to me concerning the results of such procedure(s). I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. I understand the financial policy outlined in this form associated with elected Cosmetic treatment(s), and I agree to abide by the policy outlined and explained in detail above.

Patient Printed Name & Signature:_____ Date: _____

Physician Printed Name & Signature: _____

Treating Provider Printed Name & Signature: _____

Witness Printed Name & Signature: _____

Anne Arundel DERMATOLOGY
*and Affiliate Practices*

**Date:** _____ **DOB:** _____ **MRN:** _____

**Patient Name:** _____

**Referring Provider:** _____

**MEDICATION ALLERGIES:** _____

_____

**Pharmacy Name:** _____ **Pharmacy Phone Number:** _____

**Pharmacy Address:** _____

## MEDICAL HISTORY AND INTAKE FORM

### Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat) Bone Marrow Transplantation
BPH (Enlarged Prostate)
Cancer: Type(s) _____
_____
_____
COPD (Chronic Obstructive Pulmonary Disease)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal (Kidney) Disease GERD (Acid Reflux)
Hearing Loss
Hepatitis/Liver Disease
Hypertension(High Blood Pressure)
HIV/AIDS
Hypercholesterolemia (High Cholesterol)
Hyperthyroid (Overactive Thyroid)
Hypothyroid (Underactive Thyroid)
Radiation Treatment
Seizures
Stroke
None
OTHER: _____
_____

### Have You Had Surgery On Any Of The Following Organs: (Please circle all that apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Lumpectomy (Both Breasts)
Breast: Lumpectomy (Left Breast)
Breast: Lumpectomy (Right Breast)
Breast: Mastectomy (Both Breasts)
Breast: Mastectomy (Left Breast)
Breast: Mastectomy (Right Breast)
Breast: Breast Biopsy
Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gall Bladder(Cholecystectomy): Removed
Heart: Coronary Artery Bypass Surgery
Heart: PTCA(Coronary Angioplasty)
Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant
Joint Replacement: Knee (Both)
Joint Replacement: Knee (Left)
Joint Replacement: Knee (Right)
Joint Replacement: Hip (Both)
Joint Replacement: Hip(Left)
Joint Replacement: Hip(Right)
Kidney: Kidney Biopsy
Kidney: Nephrectomy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Liver: Shunt
Liver: Liver Transplant
Liver: Hepatectomy
Ovaries(Oophorectomy): Endometriosis
Ovaries(Oophorectomy): Ovarian Cyst
Ovaries(Oophorectomy): Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas: Pancreatecomy
Prostate(Prostatectomy): Prostate Cancer
Prostate(Prostatectomy): Prostate Biopsy
Prostate:TURP(Transurethral Resection of the Prostate)
Rectum: APR(Abdominoperineal Resection)
Rectum: Lower Anterior Resection
Skin: Biopsy
Skin: Basal Cell Carcinoma
Skin: Squamous Cell Carcinoma
Skin: Melanoma
Spleen (Splenectomy)
Testicles(Orchiectomy)
Uterus(Hysterectomy): Fibroids
Uterus(Hysterectomy): Uterine Cancer
Uterus(Hysterectomy): Cervical Cancer

**OTHER:** _____

*****Please fill in reverse side of sheet also*****

## Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis (pre-cancerous lesions)
Asthma
Basal Cell Skin Cancer
Blistering Sun Burns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/ Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell 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**? If yes, which relative(s)? _____

## Social History:

Smoking Status: (Please circle one)
Current every day smoker
Current some day smoker: Tobacco
Current some day smoker: Cigarettes
Former Smoker
Never Smoker
Smoker: Current status unknown
Unknown if ever smoked
Heavy tobacco smoker
Light tobacco smoker

Alcohol Status: (Please circle one)
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

**Occupation:** _____

**Hobbies:** _____

## Family History:(please check all that apply)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Acne | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |
| Arthritis | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |
| Asthma | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |
| Diabetes | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |
| Eczema | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |
| Hay Fever/Allergies | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |
| Lupus | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |
| Psoriasis | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |
| Non-Melanoma Skin Cancers | ☐ Mother | ☐ Father | ☐ Sister | ☐ Brother | ☐ Daughter | ☐ Son | ☐ Other | ☐ None |

## Review of Systems: Do you have or are you currently experiencing any of the following? (Please circle yes or no)

| | | | | | |
|---|---|---|---|---|---|
| Changing mole | Yes | No | Muscle weakness | Yes | No |
| Rash | Yes | No | Neck Stiffness | Yes | No |
| Fever or chills | Yes | No | Headaches | Yes | No |
| Depression | Yes | No | Seizures | Yes | No |
| Anxiety | Yes | No | Cough | Yes | No |
| Problems with healing | Yes | No | Shortness of breath | Yes | No |
| Problems with bleeding | Yes | No | Wheezing | Yes | No |
| Problems with scarring (hypertrophic or keloid) Immunosuppression | Yes | No | Pacemaker | Yes | No |
| | Yes | No | Defibrillator | Yes | No |
| Hay fever | Yes | No | Blood thinners | Yes | No |
| Chest pain | Yes | No | GI upset with antibiotics | Yes | No |
| Night sweats | Yes | No | Allergy to adhesive | Yes | No |
| Unintentional weight loss | Yes | No | Allergy to lidocaine | Yes | No |
| Thyroid problems | Yes | No | Allergy to topical antibiotic ointments | Yes | No |
| Sore throat | Yes | No | Artificial heart valve | Yes | No |
| Blurry vision | Yes | No | Artificial joint within the past 2 years | Yes | No |
| Abdominal pain | Yes | No | MRSA | Yes | No |
| Bloody stool | Yes | No | Premedication prior to procedures Rapid heartbeat with epinephrine | Yes | No |
| Bloody urine | Yes | No | | Yes | No |
| Joint aches | Yes | No | Pregnancy or planning a pregnancy | Yes | No |

## Immunizations: Have you had the following immunizations?

| **Vaccine:** | **Date of Vaccination (can be approximate if unsure):** |
|---|---|
| Influenza (Flu) | _____ |
| Pneumonia | _____ |
| Varicella (Shingles) | _____ |

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**Today's Date:** _____

**Medications:**

Please list all current medications including prescriptions, over-the-counter medications, vitamins, minerals and supplements. **If not currently on medications, write NONE or N/A.**

☐ Please check box and do not fill out medication list if you have been seen in the last 6 months **AND** you gave us your medication list at that time **AND** your medication list has not changed.

| Name of Prescribed Medication | Dose | Route | Frequency |
|---|---|---|---|
| Example: Lipitor 20 mg | 1 tablet | Orally | Once a day |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Over the Counter Medication | Dose | Route | Frequency |
|---|---|---|---|
| Example: Fish Oil 1000 mg | 1 tablet | Orally | Once a day |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Patient Name:** _____ **DOB:** _____

# COSMETIC CONSULT QUESTIONNAIRE

**Patient Name:** _____ **Date of Birth:** _____

## What are your cosmetic concerns?

Please check all that apply:

- ❒ Blotchy Skin
- ❒ Brown Spots
- ❒ Eye Lash Length
- ❒ Facial Folds
- ❒ Facial Rednesss
- ❒ Fine Lines/Wrinkles
- ❒ Scarring
- ❒ Skin Tone/Texture
- ❒ Thin Lips
- ❒ Unwanted Chin/Neck Fat
- ❒ Unwanted Hair
- ❒ Veins (Facial or Leg)
- ❒ Other :_____

## Which treatment(s) interests you?

Please check all that apply:

- ❒ Botox/Dysport
- ❒ Chemical Peels
- ❒ CoolSculpting
- ❒ Cutera Laser (Brown/Red Spots)
- ❒ Dermal Fillers
- ❒ Halo (Hybrid Fractional Laser)
- ❒ HydraFacial
- ❒ Kybella
- ❒ Laser Hair Removal (LHR)
- ❒ Microneedling
- ❒ Platelet Rich Plasma (PRP) Services
- ❒ Sclerotherapy
- ❒ Skin Care Products
- ❒ Other: _____

What cosmetic procedures, if any, have you had in the past? _____

_____

_____

If yes, were you pleased with the results? _____

What skin care products, if any, do you currently use? _____

_____

_____

Do you use Retinol or Retinol-A Gel? _____

Do you have a history of cold sores or gold therapy? _____

Patient Signature _____ Date _____

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Location_____ Date_____