

PATIENT INFORMATION / CONSENT TO TREAT

Patient Name:		Social Security#	Chart #:
Mailing Address:		Home Phone:	Work Phone:
City/State/Zip		Sex:	Date of Birth:
Referring Doctor:	Ref Doc Phone #:	Marital Status:	Age:
Primary Physician:	Primary Phone #:	Employer/School:	
Emergency Contact:	Relationship	H Phone #:	Cell #:
Responsible Party:	Relationship:	Date of Birth:	Social Security#
Responsible Party Address:		City/State/Zip	Phone #:
How were you referred to us?: Patient _____ MD : _____ Insurance Co.: _____ Name: _____ Newspaper: ___ Charlotte Observer, ___ Lake Norman Mag, ___ Iredell Neighbors, ___ Mecklenburg Neighbors Yellow Pages: ___ Lake Norman ___ Charlotte ___ Other: _____			

INSURANCE INFORMATION

Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID#:	Insurance Group # :	Insurance ID#:	Insurance Group # :
Insured Name:		Insured Name:	
Address:		Address:	
City/State/Zip		City/State/Zip	
Insured DOB:	Insured Social Security# :	Insured DOB:	Insured Social Security# :

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Lakeside Cosmetic Surgery & Dermatology Center of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Lakeside Cosmetic Surgery & Dermatology for services rendered. If covered by Medicare, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment from the physicians and staff at this facility. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Signature of Patient or Authorized Person: _____	Date: _____
Insured Party or Financial Gurantor (if different from above) _____	Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices:

I have received a copy of the Lakeside Cosmetic Surgery & Dermatology Center Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a copy of the Notice by writing to the Privacy Officer, 19900 West Catawaba Avenue, Suite B, Cornelius, NC 28031 or by requesting one at the office location.

Signature of Patient or Authorized Person: _____	Date: _____
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For Staff Use Only

Patient refused to sign after he/she received Notice Of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.

Patient was initially treated for an emergency condition. Patient either was given the notice after stabilization or will be given the notice.

Signature of Staff: _____	Date: _____
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Patient Name _____ Chart # _____

**Lakeside Cosmetic Surgery & Dermatology Center
Financial Policy**

Thank you for choosing us as your dermatology provider. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

Payment is expected at the time of service. All co-pays, deductibles, and coinsurance will be collected at check out. If you have concerns regarding payment, arrangements must be made in advance.

**APPLICABLE PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, VISA, AND MASTERCARD**

Regarding Insurance

We will file claims to insurance companies we are contracted with. If we do not contract with your insurance plan, payment is required in full at the time of your visit. We cannot bill your insurance company unless you give us the correct insurance information. If you do not have your insurance card at the time of service, you will be responsible for the entire bill. Your insurance is a contract between you and your carrier. If after 60 days your insurance has not issued payment, we expect payment in full from you.

Missed Appointments

Our policy is to charge for missed appointments at the rate of \$50.00 per office visit. To avoid this charge please give our office a 24 hour advance notice when canceling an appointment. Please help us serve you better by keeping scheduled appointments.

_____ Initial

I have read, understood, and agreed to the above financial policy for payment of professional fees.

X _____
Signature of Patient or Responsible Party

Date _____

MEDICAL HISTORY
CONFIDENTIAL

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

MEDICATIONS: (PRESCRIPTION AND NONPRESCRIPTION) _____

IF FEMALE:

ARE YOU PREGNANT? _____

LAST MENSTRUAL PERIOD _____

ARE YOU BREAST FEEDING? _____

TAKING BIRTH CONTROL PILLS (NAME)? _____

MEDICAL HISTORY: (USE "C" IF CURRENT, "P" IF PAST; BE SURE TO CHECK ALL THAT APPLY)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> aids | <input type="checkbox"/> eczema | <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> STD/venereal disease |
| <input type="checkbox"/> acne | <input type="checkbox"/> epilepsy | <input type="checkbox"/> keloids | <input type="checkbox"/> stomach ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> fainting spells | <input type="checkbox"/> kidney disease | <input type="checkbox"/> stroke |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> glaucoma | <input type="checkbox"/> liver disease | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> asthma | <input type="checkbox"/> hair loss | <input type="checkbox"/> loss of skin pigment | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> allergies | <input type="checkbox"/> hay fever | <input type="checkbox"/> lung disease | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> bleeding excessive | <input type="checkbox"/> headaches | <input type="checkbox"/> lupus | <input type="checkbox"/> vitiligo |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> chronic | <input type="checkbox"/> malignant | <input type="checkbox"/> warts |
| <input type="checkbox"/> breathing disorder | <input type="checkbox"/> heart murmur | <input type="checkbox"/> melanoma | <input type="checkbox"/> wound healing difficulty |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> heart problems | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> do you have any bleeding problems |
| <input type="checkbox"/> cancer | <input type="checkbox"/> hepatitis | <input type="checkbox"/> neurological problems | <input type="checkbox"/> other conditions (describe) _____ |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> herpes simplex (cold sores) | <input type="checkbox"/> pacemaker | |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> herpes zoster (shingles) | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> colon/intestinal disorder | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> rheumatic fever | |
| <input type="checkbox"/> convulsions/seizures | <input type="checkbox"/> HIV disease | <input type="checkbox"/> scarring/keloids | |
| <input type="checkbox"/> depression | <input type="checkbox"/> hives | <input type="checkbox"/> skin cancer | |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> infections, chronic | <input type="checkbox"/> skin ulcers | |

If yes to any of the questions or you have any other medical problems, please explain: _____

No Yes Have you had a severe allergic reaction to anything? (This includes medications, creams, tape, makeup, food or latex products). Please explain: _____

No Yes Did you have a "reaction" to any anesthetics? Please explain: _____

No Yes Are you presently under the care of a physician for any illness? Please explain: _____

No Yes Have you had any serious illness, operations, or hospitalization? If so, what? _____

No Yes Have you taken Aspirin or blood thinners in the last 2 weeks? When? _____

When was your last physical examination? _____

Who is your family physician? _____

Address of physician _____

Completed by: Patient/Legal Guardian _____

Signed by Patient or Legal Guardian _____ Date _____

Medical Assistant _____ Date _____

Initials _____ Date _____

Reviewed by _____ Date _____

SUN HISTORY

Patient's Name _____ DOB _____ Date _____

In what state were you raised? _____

In what states have you lived as an adult? _____

Did you get a lot of sun as a child/ teen? _____ Have you had any sunburns? _____

Do you use tanning beds or have you in the past? _____

Do you wear hats? _____ If so what type? Ball cap _____ Wide brim _____ Visor _____

Do you wear sunscreen? _____

Do you apply it daily? _____

Do you apply it only when you are outside? _____

Do you reapply every 2 hours? _____

What number SPF do you use? _____

Have you ever had any unusual moles, skin cancer or melanoma?

Has anyone in your family ever had any unusual moles, skin cancer, or melanoma?

Do you have regular skin examinations? _____

When was your last skin examination? _____

What outdoor activities do you like/ enjoy?

Swimming ___ Waterskiing ___ Boating ___ Fishing ___ Gardening ___ Golf ___ Tennis ___

Camping ___ Hiking ___ Biking ___ Walking ___ Jogging ___ Spectator Sports ___



Nancy J. Astle, M.D.
Diplomate of American Board
of Dermatology

Ronea Harris-Stith, M.D.
Diplomate of American Board
of Dermatology

MEDICAL INFORMATION RELEASE

I give permission for Lakeside Cosmetic Surgery and Dermatology Center, P.A. to discuss my medical information with the following individuals:

Name

Relationship

Name

Relationship

Name

Relationship

Check box if you do not wish to have your medical information discussed with anyone but yourself.

Patient Signature

Date