Skye Dermatology
561-820-0155

Personal Information

Date: _____ Preferred Name: _____

Full Name: _____

Date of Birth: ___/___/___ Age: ____ SS#: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

Which Phone Number is your preferred contact number: ____H ____W ____C

Email Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Alternate Phone: _____

Home Address: _____

City/State/Zip: _____

Summer Address: _____

City/State/Zip: _____

Summer Telephone Number: _____

Insurance Information

Primary Insurance Company: _____

Type of Insurance: ____HMO ____PPO ____ COBRA ____GROUP ___Individual

Policy Holder's Name: _____ Member#: _____

Relationship to Patient: _____ Date of Birth: ___/____/____

Employer: _____ Phone: ( )____-_____

Secondary Insurance Company: _____

Policy Holder's Name: _____ Member#: _____

Relationship to Patient: _____ Date of Birth: ___/____/____

Employer: _____ Phone: ( )____-_____

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Referring Physician or Referring Family or Friend

_____

If you're not referred by a Physician or Family/Friend, how did you hear about our practice?

_____

Primary Care Physician: _____

Race/Ethnicity _____ Natural Hair Color _____ Natural Eye Color _____

Language Spoken _____

Please describe the nature of your visit:

_____

_____

_____

How long have you had the present concern: _____

Medications: (list all prescriptions, over the counter, vitamins, herbal supplements, and topical medications you are currently using)

_____

_____

_____

Drug Allergies: (list all drugs and reactions)

_____

_____

_____

Do you have any ALLERGIES to LATEX, TAPE, IODINE, OR BETADINE?

YES ____ NO_____

If YES please indicate which one(s) and list reactions

_____

Pharmacy Name: _____

Pharmacy Address:_____

Pharmacy Phone Number: _____

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Personal and Family History

Please check only those that apply to you or to a BLOOD relative:

Malignant Melanoma: Self _____ Family Member _____

Other type of Skin Cancer: Self _____ Family Member _____ Type _____

Cancer of any kind: Self _____ Family Member _____ Type _____

Do you have a history of atypical/unusual moles? Yes _____ No_____

Have you had any moles removed? Yes _____ No _____

If pathology results are known, please indicate: _____

Do you sunburn easily? _____ Have you had blistering sunburns? _____

Other Skin Conditions: _____

Are you required to take antibiotics prior to any surgical procedure? Yes_____ No_____

Please answer below: (If Yes, please indicate which)

Current tobacco use?	Yes_____ No_____
Alcohol?	Yes_____ No_____
High Blood Pressure?	Yes_____ No_____
Artificial or damaged heart valve?	Yes_____ No_____
Metal Plate, Artificial Joint, Implants?	Yes_____ No_____
Liver disease, Hepatitis, HIV?	Yes_____ No_____
Pacemaker, defibrillator?	Yes_____ No_____
History of organ transplant?	Yes_____ No_____
Kidney Disease?	Yes_____ No_____
Diabetes?	Yes_____ No_____
Seizures, Strokes, Blackouts?	Yes_____ No_____
Asthma, Emphysema, Lung Disease, Tuberculosis?	Yes_____ No_____
History of Autoimmune Disorders? (Lupus, Rheumatoid Arthritis, Scleroderma)	Yes_____ No_____
FEMALE PATIENTS: Are you currently pregnant or breast feeding?	Yes_____ No_____

Other Medical Conditions/Illnesses not listed above? _____

_____

Past Surgeries and/or hospitalizations: _____

Patient Signature:_____ Date:_____

Physician Signature: _____ Date: _____

Skye Center for Dermatology's No-Show and Cancellations Policy

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during their visit. Since appointments are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary expenditures and to contain our fees, we have implemented a No Show/Cancellation Policy for all our patients. No-show or same day cancellations will be charged a $75 fee. Upon your third no-show or same day cancellation, we reserve the right to terminate the patient-doctor relationship.

Please be assured that we strive to run our office as efficiently as possible in order to provide you the best care, and that this policy is in place to help us achieve that goal. We appreciate your understanding and cooperation in this matter.

Cosmetic Deposit and Cancellation Policy

All cosmetic consultations are $150. The fee will be deducted from the cosmetic treatment performed within 6 months of the consultation. In order to reserve your appointment, we keep a credit card on file. We will only charge the credit card if a cancellation is made on the same day or you do not show up for your appointment. If you choose to cancel your consultation, we require 48 hours notice prior to your scheduled appointment. The cancellation must be verified with one of our schedulers.

I have read the above policies and agree to the terms.

_____ _____

Patient's Signature Date

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Insurance Waiver

Dear Patient,

Please be advised that all medical services that we provided for you in our offices will be billed to your insurance company if we are contracted with your plan. You may become the liable party should your insurance company fail to pay us for the service.

Also, please be aware of what is covered and what is not covered under your particular insurance plan. We do not pre-verify benefits for all of our patients and/or diagnostic services. If there is a service that is not covered by your insurance company, you will become the liable party should your insurance company not pay.

Due to ever growing and changing insurance markets, we are unable to verify if we are participating with your insurance company. It will be left up to you to pre-verify that we are participating with your insurance company or their networks. If we do not participate with your insurance company, you will be responsible to pay for the service being rendered at the time of service, although we will provide Courtesy Billing for you.

I am signing that I have read, accept and understand the above insurance waiver for all my services.

_____ _____

Patient Name Date

_____

Signature of Patient

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Cosmetic Interest Questionnaire

(Cosmetic issues of interest to you- check all that apply)

____ Botox Cosmetic
____ AHA & Glycolic Peels
____ Filler: Restylane, Radiesse, Sculptra Juvederm
____ Microdermabrasion/Dermal Infusion
____ Fat Transplantation
____ Skin Care Products
____ Age Spots Treatment
____ Sun Protection Advice
____ Skin Care Advice
____ Skin Rejuvenation (fraxel laser)
____ Retin-A or Renova
____ Facials
____ Sun Damage
____ Spider Vein Treatment
____ Eyelash Growth/ Latisse
____ Antioxidants
____ Acne Treatment/Acne Scarring
____ Other, Please Specify: _____

Please answer the following questions by circling the appropriate answer:

When looking at my face in the mirror, I believe I look:

Much Younger Younger True Age Older Much Older

When looking in the mirror, I am _____ concerned with the appearance of my wrinkles:

Not Concerned Somewhat Concerned Very Concerned

Please list any other concern you have here: _____

_____

_____

Would you like to receive email alerts about product and procedure specials?

YES _____ NO _____

If Yes, E-Mail address: _____

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Patient Consent for Use and Disclosure of Protected Health Information

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or healthcare operations.

As our patient we want you to know that we respect the privacy of your personal medical records and we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing.

Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____
Signature of Patient or Legal Guardian

_____
Print Patient's Name Date _____

_____
Print Name of Patient of Legal Guardian, if applicable

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Contact Authorization

Patient Name: _____DOB: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ E-mail: _____

All calls regarding your care, test results and appointments will be made to your home phone. If you would like us to contact you at an alternate phone number, please indicate here:

#1: (___) _____

#2: (___) _____

_____ I hereby authorize this practice to contact me by phone and if I am not present, they **MAY** leave a detailed message on my answering machine, including results, not limited to biopsies and laboratories studies.

I grant permission for medical records to be sent to my referring physicians (may be necessary on some cases for insurance purposes) YES _____ NO _____

The following people, other than a duly designated guardian or conservator, are authorized to discuss my medical condition and/or billing information with a healthcare professional in this practice:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

_____
Signature of Patient or Legal Guardian

_____
Print Patient's Name Date _____

_____
Print Name of Patient of Legal Guardian, if applicable