

Acadia Dermatology and Aesthetic Center

Entire form *must be completed.*

Today's Date:	Referred to us by:	How Did You Hear About Our Office? <input type="checkbox"/> Internet <input type="checkbox"/> Physician <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Facebook <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other:		
Patient's First Name:		Last Name:		Date of Birth:
Mailing Address:		City/State:	Zip:	Social Security #
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American		Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Responsible Party if patient is a child: Address if different:
Home Phone:		Cell phone:		Alternate Number:
Name and Location of Pharmacy: Your prescriptions will be sent electronically to this location				
Email Address:			Emergency Contact Name and Number:	

APPOINTMENT REMINDERS: PLEASE CHOOSE ONE

- TEXT TO CELL PHONE NUMBER LISTED ABOVE EMAIL SENT TO EMAIL ADDRESS LISTED ABOVE

PRIMARY INSURANCE (please give your insurance card to the receptionist)

Primary Insurance:	Policy Holder's Name:
Policy Holder's SSN:	Policy Holder's DOB:
Patient's Relation to Card Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
If Medicare Patient, are you currently employed: <input type="checkbox"/> Y <input type="checkbox"/> N Disabled: <input type="checkbox"/> Y <input type="checkbox"/> N End Stage Renal Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	

SECONDARY INSURANCE (please give your insurance card to the receptionist)

Secondary Insurance:	Policy Holder's Name:
Policy Holder's Social Security:	Policy Holder's DOB:

My signature below acknowledges that I understand the following:

1. Co-pays and deductibles will be collected at the time of service. I am responsible for timely payment of any balance.
2. Payment for cosmetic procedures and products are due at the time of service.
3. I authorize Dr. Claiborne and Dr. Coleman to evaluate and treat my medical condition. I authorize the release of medical information as needed to my referring physician, consultants and insurance carrier to process insurance claims, applications and prescriptions. I also authorize payment of medical benefits to the physician.
4. There may be an additional charge from an outside laboratory for pathology services if a biopsy is performed.

Patient consent and Acknowledgement of Privacy Policy:

I acknowledge, understand and have been given a copy of the HIPAA Notice of Privacy Practices. HIPAA does permit sharing of information with friends/family unless the patient objects to such disclosure. **Please indicate if there is any individual you DO NOT WANT your Personal Health Information shared with.** For example: appointment reminders, medical condition or results of biopsy/tests. _____

Patient/Responsible Party Signature	Date:
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Patient Medical History

It is necessary to have this information in order to provide you with the highest quality medical care.

Past Medical History: (Please check all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Benign Prostatic Hyperplasia
- Bone Marrow Transplant
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease/Heart Disease
- Depression
- Diabetes
- End Stage Renal Disease
- Acid Reflux (GERD)
- Hearing Loss
- Hepatitis
- Hypertension (High blood pressure)
- HIV/AIDS
- High Cholesterol
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Pacemaker
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- None
- Other _____

Past Surgical History: (Please check all that apply)

- Appendix Removed
- Bladder Removed
- Mastectomy
(Right, Left, Bilateral)
- Lumpectomy
(Right, Left, Bilateral)
- Breast Biopsy
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Colectomy: Colostomy
- Gallbladder Removed
- Coronary Artery Bypass
- Angioplasty Surgery (PTCA)
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Knee Replacement
(Right, Left, Bilateral)
- Hip Replacement
(Right, Left, Replacement)
- Kidney Biopsy
- Kidney Removed (Right, Left)
- Kidney Stone Removal
- Kidney Transplant
- Liver Removed
- Liver Transplant
- Liver Shunt
- Pancreas Removed
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP
- Skin Biopsy
- Basal Cell Cancer Surgery
- Squamous Cell Cancer Surgery
- Melanoma Surgery
- Spleen Removed
- Testicles Removed
(Right, Left, Bilateral)
- Hysterectomy
- Hysterectomy: Cervical Cancer
- Hysterectomy: Fibroids
- None
- Other _____

Skin Disease History: (Please check all that apply)

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- None
- Other _____

Do you wear Sunscreen?

Y / N

Do you tan in a tanning salon?

Y / N

Do you have a family history
of Melanoma?

Y / N

If yes, how are you related?

Social History:

- Never Smoked
- Quit: Former Smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:

- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

Medications: (Please list)

None

Name and Strength:

Dosage:

How often do you take it:

Ex. Lisinopril 5mg _____

1 _____

Twice a day _____

Drug Allergies: (Please list)

I would like a free consultation with the Medical Esthetician regarding the following:

Brown Spots

Facials/Peels

Rosacea

Aging Skin

Acne

Removal of unwanted hair

Patient Name (Please print): _____

Date: _____