Acadia Dermatology and Aesthetic Center

*Entire form **must** be completed.*

Today's Date:	Referred to us by:	**How Did You Hear About Our Office?** ❑Internet ❑Physician ❑Friend/Relative ❑ Facebook ❑ Yellow Pages ❑ Other:

Patient's First Name:	Last Name:	Date of Birth:

Mailing Address:	City/State:	Zip:	Social Security #

Race: ▯ Caucasian ▯ Black ▯ Hispanic ▯ Asian ▯ Native American	Male: ❑ Female: ❑	Marital Status: ▯ Single ▯ Married ▯ Widowed ▯ 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: ❑ Self ❑ Spouse ❑ Child	
If Medicare Patient, are you currently employed: ❑ Y ❑ N Disabled: ❑ Y ❑N End Stage Renal Disease: ❑Y ❑ 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 the medical providers 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:

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
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease/Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Acid Reflux (GERD)
- ☐ Hepatitis
- ☐ Hypertension (High blood pressure)
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Seizure
- ☐ Stroke
- ☐ None
- ☐ Other _____

Past Surgical History:
(Please check all that apply)

- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Knee Replacement
- ☐ Hip Replacement
- ☐ Kidney Transplant
- ☐ Liver Transplant
- ☐ Liver Shunt
- ☐ Pancreas Removed
- ☐ Melanoma Surgery
- ☐ Hysterectomy
- ☐ None

Skin Disease History:
(Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma Year
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

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 perday
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per da

☐ No Changes in my medical history since last visit

Medications: (Please list)

- ☐ **None**
- ☐ **No changes since last visit.**

Name and Strength:	Dosage:	How often do you take it:
Ex. Lisinopril 5mg	1	Twice a day

Drug Allergies: (Please list)

_____

Patient Name (Please print): _____

Date: _____