



THE HERSCHTHAL PRACTICE

AESTHETIC DERMATOLOGY

PATIENT INFORMATION

TODAY'S DATE _____ REASON FOR TODAY'S VISIT _____

PATIENT DATA

Patient Name (First) _____ (Last) _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Marital Status Single Married Other

Male Female

PHONE

Home _____

Work _____

Mobile _____

Email _____

Preferred Contact Method _____

Pharmacy Name _____ Phone _____ City _____ Cross Streets _____

Employer _____ Employer Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Parent/Guardian of Patient _____ Phone _____

How did you hear about our office? Internet _____ Friend _____ Physician _____

INSURANCE

Primary Insurance Name _____ Name of Policy Holder _____

Policy/Member ID _____ Group # _____

CURRENT MEDICATIONS

Please list all current medications _____

LOCAL ANESTHETICS ALLERGIES

- | | | | |
|--------------------------|--|--------------------------|------------------------------------|
| YES | <input type="checkbox"/> Anesthetic | YES | <input type="checkbox"/> Lidocaine |
| <input type="checkbox"/> | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> | <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> | <input type="checkbox"/> Latex |



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PAST MEDICAL HISTORY

FAMILY MEDICAL HISTORY

FAMILY MEMBER

YES	NO		YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No relative family history	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Unknown-Adopted	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Premature Coronary Heart Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	_____
<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Melanoma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	_____

PERSONAL DERMATOLOGIIC HISTORY

FAMILY DERMATOLOGIC HISTORY

FAMILY MEMBER

YES	NO		YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Basal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Basal Cell Carcinoma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Squamous Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Squamous Carcinoma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Melanoma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dysplastic Nevus	<input type="checkbox"/>	<input type="checkbox"/>	Dysplastic Nevus	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pre Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pre Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Atopic Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	Atopic Dermatitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Acne	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cellulitis	<input type="checkbox"/>	<input type="checkbox"/>	Cellulitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Other Skin Conditions	_____

SOCIAL HISTORY

ALCOHOL		SMOKING STATUS				
<input type="checkbox"/>	Denies using alcohol	<input type="checkbox"/>	Never Smoker			
<input type="checkbox"/>	Admits alcohol use daily	<input type="checkbox"/>	Former Smoker			
<input type="checkbox"/>	Admits alcohol use socially	<input type="checkbox"/>	Occasional Smoker			
ILLEGAL DRUGS						
<input type="checkbox"/>	Denies using illegal drugs					
<input type="checkbox"/>	Admits to using illegal drugs					
STD						
<input type="checkbox"/>	Denies STD HISTORY					
<input type="checkbox"/>	Admits STD History					
Do you exercise:		Do you ever get Herpes/Cold Sores/Fever Blisters?				
<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	
ABILITY TO HEAL		YES	NO	FEMALE QUESTIONS		
	Does your skin appear fragile, burns easily	<input type="checkbox"/>	<input type="checkbox"/>	YES	NO	N/A
	Do you form thick or raised scarring from a cut or burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you wax or use depilatories on your face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEIGHT/WEIGHT

Height _____
Weight _____

OCCUPATION _____ REFERRED BY PATIENT _____

RACE _____ REFERRED BY PHYSICIAN _____

White _____ PRIMARY CARE PHYSICIAN _____

Indian _____

Native American _____

African American _____

Hispanic _____

Other _____

ETHNICITY _____

Not Hispanic Latino _____

PREFERRED LANGUAGE _____

English _____

Spanish _____

Other _____



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AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT SIGNATURE _____ DATE _____

I hereby request release of any or all of my medical records to the following Physician or person(s) named below

PHYSICIAN OR PERSON _____ ATTENTION _____

EMAIL _____

PHONE _____ FAX _____

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize the release of any medical information required by my insurance carrier(s) needed for this or any related claim. I authorize any holder and the health care financing administration or its intermediaries or carriers an information needed for this insurance claim or any related medical claim.

PRINT PATIENT NAME _____ **Date** _____

PATIENT/RESPONSIBLE PARTY'S SIGNATURE _____



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FINANCIAL POLICY

We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

ALL CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR VISIT. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND CARE CREDIT.

INSURANCE:

As a courtesy to you, we will bill your insurance company for your visit and services. You must be familiar with your own insurance terms, contract and coverage. Please be advised that it is your responsibility to verify what your insurance will cover and what it will not.

HMO REFERRALS:

It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires it for your visits. It is your responsibility to know and understand the requirements of your insurance plan. If you receive treatment that is not covered by your insurance, you will be held responsible for all services rendered.

COLLECTIONS:

Payment is due at the time services are rendered. Should your account become a collection issue, the patient/debtor assumes all costs of collection, including but not limited to collection personnel fees, court costs, interest and legal fees. Interest on accounts over 90 days past due will be 15% of the balance for every 30 days past the 90 days. The interest will accrue on the unpaid balance. You cannot be seen until your collection status has been resolved.

NON COVERED SERVICES:

Cosmetic services are not covered by insurance; payment is due at the time services are rendered. Some medical treatments may not be covered by insurance; it is your responsibility to know whether or not any and services will be covered. Cosmetic consultations are \$250.00 at the time of your visit. This fee can be applied toward any cosmetic service over \$800.00.

PRODUCT/SERVICES:

There are not guarantees in medicine. There is not guarantee that a product or service will satisfy all your needs. There are ABSOLUTELY NO REFUNDS for products or services rendered.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I HEREBY AGREE TO RENDER PAYMENT IN ACCOURDANCE WITH THE TERMS AND CONDITIONS SET FORTH ABOVE.

PRINT PATIENT NAME _____ Date _____

PATIENT/RESPONSIBLE PARTY'S SIGNATURE _____



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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing this consent, The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict your protected health information regarding treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (H.I.P.A.A.)

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations. The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice. The practice reserves the right to change the Notice of Privacy practices. The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions The patient may revoke this consent in written at any time and all future disclosures will then cease. The practice may condition receipt of treatment upon the execution of this consent.

PRINT PATIENT NAME _____ **Date** _____

PATIENT/RESPONSIBLE PARTY'S SIGNATURE _____