CENTER CITY DERMATOLOGY – STEPHEN HESS, M.D., Ph.D. - MEDICAL HISTORY

Name_____ Age_____ Date of Birth_____

Email _____

Reason for today's visit _____

Who referred you to this office?_____

Who is your primary care physician?_____

Are you allergic to any medications? _____Yes _____No If yes, list_____

Have you ever had bad reaction to dental anesthesia (Novocain)?_____

List all medications you are taking including non-prescription and over the counter

_____

_____

Are you taking blood thinners (Aspirin, Plavix, Coumadin, Motrin, Advil, Ginkgo)?

_____

Have you ever had diseases or conditions of the following? Please fill in all that apply.

Emphysema	O Yes	Asthma	O Yes	Seasonal allergies	O Yes
HIV	O Yes	High Blood Pressure	O Yes	Diabetes	O Yes
Gout	O Yes	Arthritis	O Yes	Anemia	O Yes
Seizures	O Yes	Heart murmur	O Yes	Phlebitis	O Yes
Artificial Valves	O Yes	Pacemaker	O Yes	Stroke	O Yes
Irregular heartbeat	O Yes	Hepatitis C	O Yes	Hepatitis B	O Yes
Lupus	O Yes	Artificial joint	O Yes	Heart Attack	O Yes
High Cholesterol	O Yes	Glaucoma	O Yes	Anxiety/Depression	O Yes

Other organs		**Details**
Thyroid disease	O Yes	_____
Kidney disease	O Yes	_____
Bladder problems	O Yes	_____
Stomach	O Yes	_____
Bowel	O Yes	_____
Cancer	O Yes	_____

List any other diseases or conditions we should know about_____

List any surgical procedures in the last 6 months_____

Name_____ Date of Birth_____

Without sunscreen you: O tan only O burn then tan O burn only

Have you had skin cancers? O Yes O No If yes, what kind_____

Have you had skin diseases? O Yes O No If yes, please list: _____

Any family member with **melanoma**? O Yes O No If yes, who?_____

If **65** or older - Do you have an advanced care plan? O Yes O No

Do you drink alcohol? O None O Occasionally O More than 8 drinks/week

Do you or did you ever smoke?_____Quit Date:_____

Have you ever-used IV or recreational drugs? O Yes O No

What drug?_____

Recent travel outside US in the last 3 months? O Yes O No

Occupation _____

Do you have or have had the following symptoms in the last 2 weeks? **Please fill in all that apply.**

Fever	O Yes	Weight loss	O Yes	Shortness of breath	O Yes
Fatigue	O Yes	Vision change	O Yes	Burning on urination	O Yes
Easy bruising/bleeding	O Yes	Cough	O Yes	Chest pain	O Yes
Muscle pains	O Yes	Joint pains	O Yes	Nausea, vomiting, diarrhea	O Yes
Runny nose	O Yes	Depressed moods	O Yes	Night sweats	O Yes
Headache	O Yes				

Women: are you pregnant? O Yes O No O Not sure O Planning

Women: are you menstrual periods regular? O Regular O Irregular

Women: are you breastfeeding? O Yes O No

CENTER CITY DERMATOLOGY - REGISTRATION FORM – page 3

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / Partner

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F ❑Transgender

Street address:	Social Security no.:	Primary phone no. (home / cell): ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Race:	**Ethnicity :**	Language:

Policy Holders Name:	Relation to Policy Holder: ❑ Self ❑ Parent ❑ Spouse
Primary Care Physician:	Phone No. ( )
Referring Physician:	Phone No. ( )
PHARMACY :	**PHARMACY LOCATION:**

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

We would like to take this opportunity to welcome you to our office and assure you that we will do our best to provide you with the highest quality medical care.

Financial Policy

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are requested to pay for services as rendered.

PATIENTS WITH INSURANCE COVERAGE

CENTER CITY DERMATOLOGY makes every effort to accept a broad range of major insurance carriers. However, due to the ever changing nature of health care insurance, you should always check with your specific company to ensure CENTER CITY DERMATOLOGY is in network.

We will be happy to help you obtain the appropriate benefit from your insurance carrier. We will bill your insurance carrier as a courtesy to you. However, you are responsible for the payment on the account. **Portions of the bill that are required to be paid by the patient, as per your insurance agreement, are your responsibility. These may include co-payment, co-insurance, and deductibles. Any and all balances accumulated must be paid prior to being seen for your appointments.** In the event of an outstanding balance, your account will be forwarded to a collection agency if greater than sixty (60) days past due.

If you are covered by an HMO, you are required to have a referral from your primary care doctor for all visits to CENTER CITY DERMATOLOGY. It is your responsibility to ensure that a referral is issued. As Specialists, we CANNOT see you without a referral from your primary care physician.

Please make sure that you present at the time of your appointment: drivers license, insurance, pharmacy card, and co-pay. These are required to be seen for your appointment. ***Save your receipts for your records as we do not mail out payment records for tax purposes.***

Cancellation Policy

If you are unable to keep your appointment, please call our office **at least 24 business hours** (Monday-Friday). We will reschedule that appointment to a more convenient time. Failure to show for your appointment (or late cancelations) will result in a **$50 fee**. Cancellation of a surgery or cosmetic appointment will result in a **$150 fee**. Due to the demanding schedule of our aesthetician, appointments are precious. The charge for cancellation of an aesthetics appointment is the full amount of the treatment scheduled. Please understand that we respect your time and will do everything in our power to stay on schedule. This also means that if you are late for your appointment, you may be asked to reschedule, which may also result in a charge. We recommend arriving 10-15 minutes prior to your scheduled appointment time.

Purchase Policy

We do not accept AMEX cards. All sales are final, no returns.

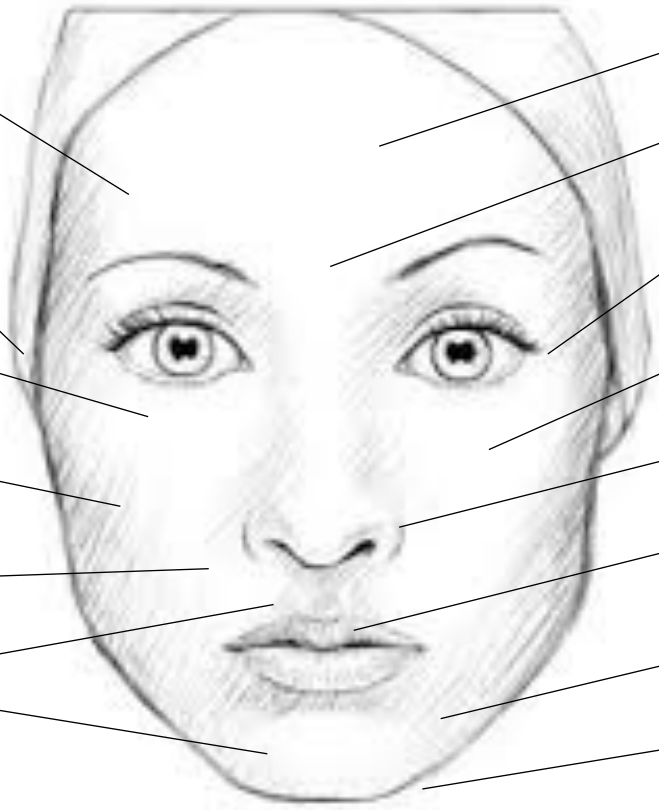
I acknowledge & understand the office policies:_____

Center City Dermatology
Cosmetic Interest Questionnaire

Name:_____ Birth Date:_____

Phone:_____ Email:_____
(To receive promotions and other news at the office, please provide your email.)

What are your concerns: (please mark all that apply)



___ Brown Spots/ Melasma

___ Split Earlobe/ Keloid

___ Dark Circles/Fine Lines/ Puffiness/ Tear Troughs

___ Acne Scarring

___ Nasal Labial Folds

___ Facial Hair

___ Forehead Wrinkles

___ Frown Lines

___ Crows Feet

___ Volume Loss

___ Broken Blood Vessels

___ Lips Lines/ Thin Lips

___ Marionette Lines

___ Double Chin

Sometimes the best results can be achieved through different products or procedures. Please let us know which of the following would be of interest to you.

- ☐ Forehead Wrinkles
- ☐ Fillers
- ☐ Lip Enhancement
- ☐ Volume Loss
- ☐ Skin Laxity
- ☐ Skin Discoloration (Melasma, Brown Spots)
- ☐ Facial Veins/ Red Spots/ Broken Blood Vessels
- ☐ Eyelash Enhancement (Latisse)
- ☐ Hair Removal
- ☐ Skin Care Products
- ☐ Chemical Peels
- ☐ Scarring (ie. acne)
- ☐ Double Chin
- ☐ Stubborn Unwanted Fat
- ☐ Cellulite
- ☐ Skin Tightening

Patient Signature:_____ Date:_____

AUTHORIZATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HERBY AUTHORIZE CENTER CITY DERMATOLOGY TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO CENTER CITY DERMATOLOGY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

HIPAA ACKNOWLEDGEMENT:

I HAVE READ CENTER CITY DERMATOLOGY NOTICE OF PRIVACY PRACTICES.

IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:

_____

(Please list authorized Representative(s) or mark N/A)

Patient Signature (or Parent/Guardian Signature) **Date**

CENTER CITY DERMATOLOGY