Auburn Dermatology & Laser Center
(Please Print **Legibly**)

Legal Name ______________________________ **Preferred/Nickname** ______________

Mailing Address ______________________________ **City** ______________ **State** ____ **Zip** ________

Primary Phone ______________________________ **Secondary Phone** ______________________

Sex Male / Female **Marital Status** S M W D **Date of Birth** ____/____/______

Email (for reminder emails) ____

Pharmacy Name ______________________ **Pharmacy Location** ______________________

Primary Care Physician Name ____

Emergency Contact Name & Phone Number ______________________________________

PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES, i.e. YOUR COPAYMENT. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the provider to release such medical information necessary to process your insurance claims. You authorize payment of medical benefits to the provider when the assigned claim is filed. ATTENTION: I understand that if my insurance company requires an insurance referral, I am responsible for obtaining an insurance referral prior to my visit. If I do not have an insurance referral, I understand that my appointment will either be rescheduled, or I will be responsible for the full amount of the charges.

____
Signature of Patient or Legal Guardian

____
Date

HIPAA

DO WE HAVE PERMISSION TO:

Leave a message on your phone? Yes / No

Discuss your medical condition with any other person? Yes / No

If yes, whom? ______________________________ Relationship ______________

______________________________ Relationship ______________

I have reviewed Auburn Dermatology & Laser Center's HIPAA notice of privacy practices (at check-in)

____
Signature of Patient or Guardian

____
Patient's Printed Name

____
Date

Financial Policy

We would like to thank you for choosing Auburn Dermatology as your dermatology provider. We, at Auburn Dermatology, are committed to providing you with the best possible medical care. We are sure that you understand that payment for this care is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

FOR PATIENTS WITHOUT MEDICAL INSURANCE:

A $150 charge is due at the time of the first visit with Auburn Dermatology. Any subsequent visits from then on are $75, unless otherwise quoted by staff member.

FOR PATIENTS WITH MEDICAL INSURANCE:

We participate in most major health plans. We have contracts with many HMO's and PPO's, insurance companies and government agencies including Medicare and some Mass Health policies. Our billing office will submit claims for any medically necessary services rendered to a patient who is a member of one of these plans, and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as your primary carrier has paid. Your insurance company may need you to supply certain information directly, it is your responsibility to comply with their request.

Please bring your insurance card and copayment with you at the time of your appointment. If you are insured by a plan that we do participate in, but do not have your insurance card with you, payment in full for each visit is required until we can verify your coverage. If a patient is a member of an insurance plan with which we do not participate, payment in full is due at the time of service.

COPAYMENTS:

Your insurance company requires us to collect copays at the time of service. Waiver of copays may constitute fraud under State and Federal law. Please help us in upholding the law by paying your copay at each visit. For your convenience, we accept cash, check, Visa, Mastercard, Discover and American Express. IF YOU DO NOT HAVE YOUR COPAY, YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.

PATIENT BALANCES:

All patient balances must be paid in full within 30 days of receiving your bill from Auburn Dermatology. A $25 service fee will be added to any account that becomes delinquent.

____
Patient's Printed Name

____
Patient/Guardian Signature

____
Date

Auburn Dermatology and Laser Center

1) Patients who fail to cancel or present for a scheduled appointment without contacting the practice to cancel their appointment within 24 hours will be considered a "No Show"

2) Any patient who does not show up for their appointment is considered a "No Show"

3) Patients who "No Show" three times will be reviewed for possible dismissal from the group.

4) It is our intention to communicate with our patients to prevent "No Shows"

5) All patients will be notified of the Cancellation and No Show Policy and will need to sign the "Acknowledgement Receipt" at the time of registration.

6) This policy is effective immediately.

7) In situations of inclement weather, the practice may not consider the patient a "No Show".

8) New patients will be reviewed for dismissal after the second "No Show".

9) Patients will be notified in writing of the first missed appointment.

10) Patients will be notified in writing of their second missed appointment and will be billed a $25.00 "No Show" fee.

11) On the third missed appointment, the patient will be sent a letter discharging them from the practice. The practice will continue to see the patient for urgent appointments for 30 days in order for the patient to transition to another office for their care.

____
Patient printed name

____
Patient / Guardian Signature

(Office use only) Medical Record Number: ________________________

Patient Name: ______________________________ Name / Location of Pharmacy

____

____

Past Medical History (Circle all that Apply)

Anxiety	Arthritis	Artificial Joints	Valve Replacement
Hearing Loss	Hepatitis	COPD	Coronary Artery Disease
Stroke	Depression	Diabetes	End Stage Renal Disease
Asthma	Lymphoma	Pacemaker	Hypercholesterolemia
Breast Cancer	Colon Cancer	Seizures	Leukemia
Lung Cancer	GERD	Atrial Fibrillation	Hyperthyroidism
Hypothyroidism	HIV/AIDS	Benign Prostatic Hyperplasia	Hypertension
Prostate Cancer	Radiation Treatment	Bone Marrow transplantation	
			NONE

Other:

____

Past Surgical History (Circle all that Apply)

Appendix Removed	Bladder Removed	Breast Reduction	Mastectomy (R/ L/Both)
Breast Implants	Gallbladder Removed	Heart Transplant	Lumpectomy (R / L / Both)
TURP	Skin Biopsy	Prostate Biopsy	Kidney Stone Removal
Kidney Biopsy	Kidney Transplant	Kidney Removed	Breast Biopsy
Colectomy	Ovaries Removed	Testicles Removed	Spleen Removed
Prostate Removed	Melanoma Surgery	PTCA	Heart Stents
Hysterectomy	Coronary Artery Bypass	Valve Replacement (Mechanical / Biological)	
Knee Replacement (R / L / Both)		Hip Replacement (R / L / Both)	
Squamous Cell Carcinoma Surgery		Basal Cell Carcinoma Surgery	
		NONE	

Other:

____

Skin Disease History (Circle all that Apply)

Acne	Eczema	Psoriasis	Squamous Cell Carcinoma
Actinic Keratosis	Flaking / Itching Scalp	Asthma	Basal Cell Carcinoma
Blistering Sunburns	Melanoma	Poison Ivy	Precancerous Moles
Hay Fever / Allergies	Dry Skin	NONE	

Other:____

Do you wear sunscreen? Yes / No If yes, what SPF? _________ Do you tan in a tanning salon? Y/ N

Do you have a family history of Melanoma? Yes / No If yes, which relative(s) ______________

Social History (Circle all that Apply)

Currently Smokes (Daily / Not Daily)	Has Never Smoked	Has Smoked in the Past
Recreational Drug Use	Drinks Alcohol / Frequency______________	NONE

Other:

____

Medications ______________________ Allergies ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Medical History: Review of Systems

Circle yes or no if you CURRENTLY have the following conditions:

Allergy/Immunologic
- Yes No Premedication prior to procedure
- Yes No Allergy to Adhesive
- Yes No Allergy to Topical Antibiotic Ointments
- Yes No Allergy to Lidocaine
- Yes No Immunosupression
- Yes No Hay Fever
- Yes No Allergy to Latex

Integumentary/Skin
- Yes No Rash
- Yes No Changing Mole
- Yes No Problems with Healing
- Yes No Problems with Scarring (Keloid)

Hematology/Lymphatic
- Yes No Blood Thinners
- Yes No Problems with Bleeding

Endocrine
- Yes No Thyroid problems
- Yes No Are you Pregnant or Planning a Pregnancy
- Yes No Are you Currently Breastfeeding

Respiratory
- Yes No Wheezing
- Yes No Shortness of Breath
- Yes No Cough

Neurological
- Yes No Headaches
- Yes No Seizures

Eyes
- Yes No Blurry Vision

Cardiovascular
- Yes No Pacemaker
- Yes No Defibrillator
- Yes No Artificial Joints (past two years)
- Yes No Artificial Heart Valve
- Yes No Rapid Heart Beat with Epinephrine
- Yes No Chest Pain

Gastrointestinal (G.I.)
- Yes No Abdominal Pain
- Yes No Bloody Stool
- Yes No GI Upset with Antibiotics

Musculoskeletal
- Yes No Joint Aches
- Yes No Neck Stiffness
- Yes No Muscle Weakness

Psychiatric
- Yes No Anxiety
- Yes No Depression

Constitutional/Symptom
- Yes No Swollen Lymph Nodes
- Yes No Yeast Infections with antibiotics
- Yes No Unintentional Weight Loss
- Yes No Fever or Chills
- Yes No Night Sweats

Genitourinary
- Yes No Bloody Urine

ENT and Mouth
- Yes No Sore Throat