



CHOICE DERMATOLOGY

Marc Meulener MD, PhD

Patient Information

Name _____ Address _____

(First) (MI) (Last) City/State/Zip _____

Social Security Number _____ Date of Birth _____

Primary Phone _____ (home/cell/work) Secondary Phone _____ (home/cell/work)

E-mail: _____ (Our use only) Contact Method: phone / e-mail / text

Emergency Contact/relationship _____ Phone Number _____

Primary Physician _____ Address _____

Phone _____ City/State/Zip _____

Gender ___ Male ___ Female

Race(s) ___ White ___ Black or African American ___ Hispanic ___ Asian ___ Decline to Specify

Insurance Information

Primary Insurance Company _____

Address _____ Phone _____

ID Number _____ Group Number _____

Primary Insured (If Different From Above)

*Responsible Party Name _____ Sex: Male/Female

*Date of Birth _____ Address (if different) _____

Home Phone _____ Cell Phone _____

Relationship to Patient _____

Responsible Party's Employer Company _____ City _____

* required for billing

Do you have additional insurance? If yes, complete the following

Secondary Insurance Company _____ Phone _____

ID Number _____ Group Number _____

Subscriber's Name _____ DOB _____ Relationship to patient _____

Medical History (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> BPH (Benign Prostatic Hyperplasia) | <input type="checkbox"/> GERD | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |

Other _____

Other Medical (Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Artificial heart valve |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Rapid heartbeat with epinephrine | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Problems with scarring (keloid) | <input type="checkbox"/> Premedication prior to procedure | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Pregnancy or planning pregnancy | | |

Do you have any other medical history that you would like Dr. Meulener to be aware of?

Surgical History (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Biopsy |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Kidney Removed (Right, Left) |
| <input type="checkbox"/> Breast: Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Breast: Lumpectomy (Right, Left, Bilateral) | <input type="checkbox"/> Liver: Hepatectomy |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Liver: Transplant |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Liver: Shunt |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Ovaries Removed: Endometriosis |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Ovaries Removed: Cyst |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer |
| <input type="checkbox"/> Colectomy: Inflammatory Bowel Disease | <input type="checkbox"/> Prostate Removed: Prostate Cancer |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Heart: Coronary Artery Bypass | <input type="checkbox"/> Prostate: TURP (Transurethral Resection of Prostate) |
| <input type="checkbox"/> Heart: PTCA (Percutaneous Transluminal
Coronary Angioplasty) | <input type="checkbox"/> Skin: Skin Biopsy |
| <input type="checkbox"/> Heart: Mechanical/Biological Valve Replacement | <input type="checkbox"/> Skin: Basal Cell Carcinoma |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Skin: Squamous Cell Carcinoma |
| <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) | <input type="checkbox"/> Skin: Melanoma |
| <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Bilateral) | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Joint Replacement Within last 2 Years | <input type="checkbox"/> Uterus/Hysterectomy: Fibroids |
| | <input type="checkbox"/> Uterus/Hysterectomy: Uterine Cancer |
| | <input type="checkbox"/> Uterus/Cervical Cancer |

Other _____

Patient Name _____ DOB _____ Visit Date _____

Do you have any of the following skin conditions (please check all that apply)

- Acne
- Dry Skin
- Hay Fever/Allergies
- Precancerous Moles
- Actinic Keratosis
- Eczema
- Melanoma
- Psoriasis
- Basal Cell Skin Cancer
- Flaking/ itchy scalp
- Poison Ivy
- Squamous cell skin cancer
- Blistering Sunburns
- Other _____

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

Do you have a family history of melanoma? Yes/No If yes, which relative? _____

Medications: all current Prescriptions /Vitamins/Supplements/Herbal Remedies/ OTCs i.e., aspirin, ibuprofen

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Form: pill, patch</u>	<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Form: pill, patch</u>
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Vaccinations: Please list the dates (or “do not know”) of your most recent vaccinations for:

Influenza: _____ Pneumonia: _____ Tetanus: _____

Allergies to Foods and Medications including Lidocaine and Latex (please specify reactions)

Pharmacy and Location _____

(Please check one)

- Alcohol Use:**
- No alcohol use
 - Less than 1 drink per day
 - 1-2 drinks per day
 - 3+ drinks per day

(Please check all that apply)

- Tobacco Use:**
- Has never smoked
 - Currently smokes: Daily? Y / N
 - Has smoked in the past
 - Total number of years smoking _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES, ELECTRONIC ACCESS, AND OFFICE PROCEDURES

A scanned copy of this authorization shall be considered as valid as the original.

This authorization may be revoked by me in writing.

1. PRIVACY PRACTICES AND RELEASE OF MY PROTECTED HEALTH INFORMATION

I may refuse to sign this acknowledgement.

I have received a copy of Choice Dermatology LLC's Notice of Privacy Practices.

I hereby authorize the Physician to release any information acquired in the course of my examination or treatment to my referring physician and/or to my insurance carrier, information needed to determine benefits

2. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby assign payment directly to the Physician for the Surgical and/or Medical benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to Physician for those services. I understand that I am financially responsible for charges not covered by insurance.

3. CANCELLATION POLICY

I understand that if I cancel or change my appointment with less than 24 hours notice, I may be charged \$25.00. The charge for cancellation of a cosmetic appointment or patch testing less than 24 hours from you appointment is \$100 - this includes Botox, Filler, Laser, TruSculpt, Microneedling, and any other cosmetic procedures. Deposits of \$50 are required to hold a spot for Acne Facials or Age-Defying Facials/peels and the deposit is non-refundable if cancellation occurs within 24hrs of appointment time.

4. INSURANCE VERIFICATION:

It is your responsibility to provide up to date medical insurance information and to notify us of any changes in your insurance coverage. You are personally responsible for all charges incurred. Failure to provide accurate insurance information that results in non-payment for services, or denial of claims from insurance, will result in charges to your account, plus an additional fee of \$25 for inactive or terminated insurance. This charge is added to account for processing costs to the practice.

5. COLLECTIONS:

If you fail to make any payment when due to Choice Dermatology, we have the right to refer your account to a third party for collection (a collection agency). You will be responsible for all costs associated with collections including an Administration Fee of \$35.

6. ELECTRONIC MEDICAL RECORD ACCESS

I am aware that I will be assigned a portal for electronic access to my medical record. The practice will provide me a username and password via paper or email.

Signature of Patient or Parent if Patient is a Minor

Date

AUTHORIZATION FOR THE RELEASE OF MY MEDICAL INFORMATION TO THIRD PARTY

The following person(s) may receive medical information on my behalf:

Please Print Name(s)/Relationship

Patient's signature

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual Refused to Sign

Communications barriers prohibited obtaining the acknowledgement

CREDIT CARD on FILE AGREEMENT

Choice Dermatology has implemented a credit card policy. We require keeping your credit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable.

Co-pays are still due at the time of service.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card.

A COURTESY CALL WILL BE RECEIVED THE DAY OF, BEFORE THE CARD WILL BE CHARGED.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize **CHOICE DERMATOLOGY** to keep my signature and my credit card information securely on file in my account. I authorize **CHOICE DERMATOLOGY** to charge my credit card for any balances due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give **CHOICE DERMATOLOGY** a new, valid credit card. I agree that the new card may be used with the same authorization as the original card I presented.

Print Patient Name(s):

_____	DOB: _____
_____	DOB: _____
_____	DOB: _____
_____	DOB: _____

Name on Card: _____

Credit Card Number: _____ Exp. Date: _____

CVV or Security Code: _____ Billing Zip Code: _____

Credit Card Holder's Signature: _____

DATE SIGNED