Clearlyderm
Dermatology

PATIENT INFORMATION:

Today's Date _____

First Name _____ Last Name _____ Middle _____

Address _____ Apt. _____ City _____ State _____ Zip _____

E-Mail Address _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Date of Birth _____ Age _____ Social Security Number _____ Sex: ❑ M ❑ F
Last four digits of your SSN only!

Marital Status: ❑ S ❑ M ❑ W ❑ D Spouse / Partner Name _____ Phone (_____) _____

Employer (company name if self employed) _____ Occupation _____

Primary Physician _____ Office Phone (_____) _____

Preferred Pharmacy _____ Pharmacy Phone (_____) _____

Emergency Contact _____ Relationship _____ Phone (_____) _____

INSURANCE INFORMATION: *(IN ORDER TO BILL YOUR INSURANCE COMPANY, THIS SECTION MUST BE COMPLETED IN FULL)*

PRIMARY Insurance Policy _____ Policy or ID # _____ Group # _____

Insurance Customer Service Phone Number (_____) _____

Policy Holder's Information *(if different than patient)*

First Name _____ Last Name _____ Middle _____ S.S. # _____ Sex: ❑ M ❑ F
Last four digits of your SSN only!

Date of Birth _____ Work Phone (_____) _____ Employer _____

SECONDARY Insurance Policy _____ Policy or ID # _____ Group # _____

Insurance Customer Service Phone Number (_____) _____

Policy Holder's Information *(if different than patient)*

First Name _____ Last Name _____ Middle _____ S.S. # _____ Sex: ❑ M ❑ F
Last four digits of your SSN only!

Date of Birth _____ Work Phone (_____) _____ Employer _____

HOW DID YOU HEAR ABOUT US:

❑ Advertisement ❑ My Doctor ❑ Family Member ❑ Friend ❑ Saw Your Sign ❑ Insurance Directory ❑ Internet ❑ Other _____

I AM INTERESTED IN ADDITIONAL INFORMATION ON:

- ❑ **Botox®:** Eases wrinkles on the forehead; smooths lines around the eyes and mouth
- ❑ **Facial Fillers:** Corrects volume loss and wrinkles
- ❑ **DermaSweep™ Microdermabrasion:** Next generation microdermabrasion with customized skin infusions to treat sun damage, hyperpigmentation and premature aging
- ❑ **Facials & Extractions:** Deep cleansing facial utilizing ultrasonic waves to gently treat various skin conditions and penetrate healing antioxidants deep into the skin
- ❑ **Chemical Peels:** Refines, tones and clarifies skin
- ❑ **Laser Hair Removal:** Permanent hair reduction
- ❑ **Laser Treatments:** For vascular (red) or pigmented (brown) spots
- ❑ **ClearlyDerm™ Acne Program:** Medical grade skincare products; take home regimens prescribed just for you to assist you in achieving and maintaining healthy skin
- ❑ **Sclerotherapy**

RECORD RELEASE & ASSIGNMENT OF BENEFITS:

I hereby authorize ClearlyDerm LLC to release pertinent information regarding my care to other physicians involved in my case and / or insurance companies holding policies on me. I authorize my insurance company to directly remit payment to ClearlyDerm LLC for medical or surgical services provided and billed.

X _____ **X** _____ **X** _____
Print Patient Name Signature Date

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FINANCIAL POLICY:

- Payment is due at the time of service, including co-payments and deductibles.
- All charges will become the patient's financial responsibility if your insurance carrier has not paid within 60 days.
- All cosmetic procedures are paid at the time of service. We do not bill these procedures to insurance companies.
- I understand that if blood work or biopsies are done that I may receive a separate invoice from the laboratory or the pathology doctor who review and interprets my biopsy specimens at a later date. I will be responsible for paying all such invoices directly to that laboratory or physician.
- **I have read and fully understand ClearlyDerm LLC's financial policy.**

*****THIS SHOULD BE SIGNED BY THE PERSON RESPONSIBLE FOR PAYMENT*****

Signature_____

Printed Name_____ Date_____

Relationship _____

AUTHORIZATION TO DISCUSS/RELEASE MEDICAL INFORMATION & CONSENT FOR TREATMENT

(optional) I authorize_____, who is my _____ to have access to / discuss my medical records.
(Name) (Relationship)

I ❑ AUTHORIZE, ❑ DO NOT AUTHORIZE, Clearlyderm employees to release my medical information through telephone communication to myself or the identified people listed on my HIPPA form.

I ❑ AUTHORIZE, ❑ DO NOT AUTHORIZE, Clearyderm to leave medical information on my voice message on this designated telephone number (_____)_____

I ❑ AUTHORIZE, ❑ DO NOT AUTHORIZE, Clearyderm to send medical information to my phone via text message on this designated telephone number(_____)_____

I ❑ AUTHORIZE, ❑ DO NOT AUTHORIZE, Clearyderm to send medical information to my email at the designated email address _____

You give ClearlyDerm LLC and it's healthcare providers, authorization to perform medical treatment, therapy, and medication that may be indicated.

X_____ **X**_____ **X**_____
Signature Printed Name Date

A PARENT OR GUARDIAN MUST ACCOMPANY A MINOR TO THE INITIAL VISIT
MINOR CONSENT: THIS SHOULD BE SIGNED IF THE MINOR WILL NOT BE WITH A PARENT, EXCEPT FOR THE INITIAL VISIT

I give the doctors and staff at ClearlyDerm permission to treat _____ in my absence.
(Name)

X_____ **X**_____ **X**_____
Signature Printed Name Date

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PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

Patient's Name _____ Date _____

- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Atrial fibrillation
- ❒ Bone Marrow Transplant
- ❒ Breast Cancer
- ❒ Colon Cancer
- ❒ COPD
- ❒ Coronary Artery Disease
- ❒ Depression
- ❒ Diabetes
- ❒ Renal Disease
- ❒ Hepatitis Type: ❒ A ❒ B ❒ C
- ❒ Hypertension
- ❒ HIV/AIDS
- ❒ Hypercholesterolemia
- ❒ Hyperthyroidism
- ❒ Hypothyroidism
- ❒ Inflammatory Bowel Disease
- ❒ Glaucoma
- ❒ Leukemia
- ❒ Lung Cancer
- ❒ Lymphoma
- ❒ Pacemaker
- ❒ Prostate Cancer
- ❒ Radiation Treatment
- ❒ Seizures
- ❒ Stroke
- ❒ Other _____
- ❒ **None**

PAST SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ❒ Appendix Removed
- ❒ Bladder Removed
- ❒ Mastectomy: ❒ Left ❒ Right
- ❒ Lumpectomy: ❒ Left ❒ Right
- ❒ Breast Implants
- ❒ Gallbladder Removed
- ❒ Coronary Artery Bypass
- ❒ Valve Replacement
- ❒ Heart Transplant
- ❒ Joint Replacement
  ❒ Knee ❒ Hip ❒ Right ❒ Left
- ❒ Kidney Removed
- ❒ Kidney Transplant
- ❒ Ovaries Removed Due To:
  ❒ Endometrosis ❒ Cancer ❒ Cyst
- ❒ Prostate Removed
- ❒ Spleen Removed
- ❒ Hysterectomy Due To:
  ❒ Fibroids ❒ Cervical Cancer ❒ Uterine Cancer
- ❒ Tuballigation
- ❒ Other _____
- ❒ **None**

SKIN DISEASE HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ❒ Acne
- ❒ Actinic Keratoses
- ❒ Asthma
- ❒ Basal Cell Skin Cancer
  Location _____ Year _____
- ❒ Blistering Sunburns
- ❒ Dry Skin
- ❒ Eczema
- ❒ Flaking or Itchy Scalp
- ❒ Hay Fever/Allergies
- ❒ Melanoma
  Location _____ Year _____
- ❒ Poison Ivy
- ❒ Precancerous Moles
- ❒ Psoriasis
- ❒ Squamous Cell Skin
  Location _____ Year _____
- ❒ Other _____
- ❒ **None**

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 skin cancer? ❑ Yes ❑ No; if Yes, Type: ❑ Melanoma ❑ Basal / Squamous Cell ❑ Unsure
If Melanoma, which relative(s)? _____

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CAUTIONS: (PLEASE CHECK ALL THAT APPLY)

Do you have a pacemaker? ❑ Yes ❑ No
Do you have a defibrillator? ❑ Yes ❑ No
Have you had an artificial joint replacement? ❑ Yes ❑ No
If yes, when and what body locations? _____
Do you have an artificial heart valve? ❑ Yes ❑ No
Do you require antibiotics prior to a surgical procedure? ❑ Yes ❑ No
Allergy to adhesives? ❑ Yes ❑ No
Allergy to topical antibiotic ointments? ❑ Yes ❑ No
Are you taking blood thinners or aspirin? ❑ Yes ❑ No
Are you pregnant or currently trying to get pregnant? ❑ Yes ❑ No
Are you allergic to lidocaine? ❑ Yes ❑ No
Do you get rapid heartbeat with epinephrine? ❑ Yes ❑ No
Do you get yeast infections with antibiotics? ❑ Yes ❑ No
Do you get GI upset with antibiotics? ❑ Yes ❑ No

MEDICATIONS: (PLEASE ENTER ALL CURRENT MEDICATIONS, INCLUDING VITAMINS AND OVER-THE-COUNTER)

ALLERGIES: (PLEASE ENTER ALL ALLERGIES TO MEDICATIONS)

❑ Currently Smokes ❑ Has smoked in the past ❑ Never Smoked
❑ Other _____
❑ None

SIGNATURE:

Completed by: ❑ Patient ❑ Patient's Parent ❑ Guardian ❑ Medical Assistant

Print Name (if not patient): _____

X _____ X _____ X _____
Print Patient Name Signature Date

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HIPAA PRIVACY PATIENT CONSENT FORM:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. 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 how protected health information about you is used or disclosed for treatment, payment and health care operations. You have the right to revoke this consent this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures 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 (HIPAA).

The patient understands that:

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

X _____

Signature

This Consent was signed by _____

Printed Name – Patient or Representative

Please bring this completed form to your first appointment