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Lotus Dermatology

Center for Aesthetic Plastic Surgery

Patient Name: _____
Last First MI

Address: _____

City: _____ **State**:_____ **Zip Code**: _____

Date of Birth: _____/_____/____ **Marital Status**: S M W D **Spouse's Name:**_____

Home Phone: _____ **Cell Phone**: _____

Can you receive calls? Yes___ No___ **Is it okay to leave a voicemail?** Yes___ No___

Can you receive emails? Yes___ No___ **Email**: _____

Primary Physician: _____ **Referring Physician**: _____

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

OR

☐ ***I would like to opt out of this, and by opting out, I understand that I WILL NOT get an appointment reminder. I also understand there is a $25 fee for missed office appointments and a $50 fee for missed surgical appointments.***

HIPAA NOTIFICATION

I understand the Center for Aesthetic Plastic Surgery, dba **Lotus Dermatology,** has made available to me a copy of the Notice Of Privacy Practices. By signing below, I acknowledge the availability of the Notice of Privacy Practices. **(If you would like a copy of this notice, please ask any staff member.)**

PATIENT SIGNATURE: _____ DATE:_____

Because the nature of this practice, it may be necessary to contact you by telephone for biopsy results, surgery scheduling, appointments, billing, etc. HIPAA requires that we obtain specific consent from our patients allowing us to speak with others on your behalf or leave a message should you not be available. Please indicate the names, relationship, date of birth, and phone number of those of you will allow us to speak with on your behalf.

This will include your SPOUSE, FAMILY MEMBERS, CARE GIVERS, ETC.

NAME: _____ **NAME: _____**

RELATIONSHIP: _____ **RELATIONSHIP: _____**

DATE OF BIRTH: _____ **DATE OF BIRTH: _____**

PHONE NUMBER: _____ **PHONE NUMBER: _____**

PATIENT SIGNATURE: _____ DATE: _____

OR

If you **DO NOT** want us to speak with anyone with regards to your treatment, appointments, billing, etc., please indicate by signing below.

PATIENT SIGNATURE: _____ DATE:_____

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History and Intake Form

Past Medical History: (Please circle all that apply)

Anxiety	Lung Cancer	Radiation Treatment
Coronary Artery Disease	Atrial Fibrillation	Breast cancer
Hyperthyroidism	End Stage Renal	HIV/AIDS
Hypothyroidism	Lymphoma	Seizures
Arthritis	Bone Marrow	Colon Cancer
Depression	GERD	High Cholesterol
Leukemia	Prostate Cancer	Stroke
Asthma	Transplantation	COPD
Diabetes	High Blood Pressure	NONE

Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Breast Implants
Bladder Removed	Kidney Transplant
Joint Replacement within last 2 years	Colectomy: Colon Cancer Resection
Mastectomy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Kidney Biopsy (Nephrectomy)	Colectomy: Diverticulitis
Lumpectomy (Right, Left, Bilateral)	Ovaries Removed: Cyst
Kidney Removed (Right, Left)	Ovaries Removed: Ovarian Cancer
Breast Biopsy (Right, Left, Bilateral)	Colectomy: IBD
Kidney Stone Removal	Heart Transplant
Gallbladder Removed	Hysterectomy: Fibroids
Prostate Biopsy	Joint Replacement-Knee (Right, Left, Bilateral)
Coronary Artery Bypass	Hysterectomy: Uterine Cancer
TURP (Prostate Removal)	Joint Replacement-Hip (Right, Left, Bilateral)
Mechanical Valve Replacement	Heart: pacemaker/defibrillator
Spleen Removed	Joint Replacement- Shoulder (Right, Left, Bilateral)
Biological Valve Replacement	
Testicles Removed (Right, Left, Bilateral)	

NONE Other: _____

History of Skin Disorder :(Please circle all that apply)

Actinic Keratosis	Rosacea	Varicella Zoster Virus (Shingles)
Bacterial Skin Infections/MRSA	Allergic/Irritant Dermatitis	Keloid/Hypertrophic Scar
Basal Cell Carcinoma	Contact Dermatitis	Blistering Sunburns
Squamous Cell Carcinoma	Urticaria/ Hives	Lupus
Mycosis Fungoid (CTCL)	Seborrheic Dermatitis	Psoriasis
Melanoma	Herpes Simplex Virus (HSV)	Eczema
Acne	Pre-cancerous moles	NONE

Other: _____

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

Do you have family history of Basal Cell or Squamous Cell Carcinoma? Yes No
Do you have family history of Melanoma? Yes No
If yes, which relative(s): _____

Medications: (Please list all current medications including any daily vitamins)
_____
_____
_____

Allergies: (Please list all allergies)
_____

Social History: (Please Circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently smokes: ____ Packs/Day	None
Former Smoker	Less than 1 drink per day
Never Smoked	1-2 drinks per day
	3 or more drinks per day

Other: _____

Review of Systems: Are you currently experiencing any of the following? (Please check YES or No for the following.)

SYMPTOMS	YES	NO
History of new or changing moles		
Problems with bleeding/easy bruising		
Problems with scarring		
Problems with Healing		
Fevers/Chills/Sweats		
Unintentional weight loss		
Sore throat		
Blurry Vision		
Abdominal Pain		
Joint aches/Muscle weakness		
Headaches		
Anxiety		
Depression		

Other Symptoms: _____

Do you have family history of any major illnesses including Cancer, Heart Disease, Diabetes, etc..? (First degree relatives: Parents and siblings)

_____
_____
_____
_____

Alerts: (Please circle all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Allergy to antiseptic solution (iodine)
Allergy to latex
Allergy to oral antibiotics
Allergy to epinephrine
Artificial heart valve
Artificial Joint (Hip/Joint)
Replacement year: _____
Blood thinners: (please specify)
_____
Bleeding disorders
History of Hepatitis C
History of Hepatitis B
History of Tuberculosis
History of HIV
Immunosuppressed
MRSA
Organ transplant
Pacemaker/Defibrillator
Poor wound healing
Prone to fainting with procedures/needles
Bad scarring (keloid/hypertrophic)
Require antibiotics prior to a surgical/dental procedure
Pregnant or currently trying to get pregnant
Rapid heartbeat with epinephrine
Radiation treatment
other: _____
None

Pharmacy Name: _____

Address: _____

Phone: _____

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize Center for Aesthetic Plastic Surgery, P.A. to release information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) to make a payment directly to Center for Aesthetic Plastic Surgery, P.A. for the surgical and/or medical benefits payable for the services rendered.

_____ _____

Patient /Parent Signature Date

FINANCIAL POLICY

The doctors and staff of **The Center for Aesthetic Plastic Surgery** would like to welcome you to our practice. We strive to provide you with professionalism and excellent care.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- It is your responsibility to inform our office of appointment cancellations 24 business hours prior. Failure to notify of cancellation/no show may result in a **$25** charge and a **$50** charge for cancellation/no show of surgical appointments.
- Your account is to be kept current-accordingly, all cosmetic fees, self-pay or insurance co-payments, co-insurance and deductibles will be collected at the time of service. Payable by cash, check or credit card.
- If you do not have your payment(s), your appointment may be rescheduled.
- A returned check will result in a $25 service charge and all future payments being required in the form of cash or credit card.
- There may be a $25 fee for the completion of any paperwork (ex: disability, worker's compensation forms, insurance, etc.).
- There is a fee for copying medical records: **$1.00/page** for the first 25 pages and **$0.25** for every page thereafter.

If you have health insurance coverage:

We will submit your claims, however we must emphasize that as medical providers, our relationship is with you, not your insurance company. Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on information given to us at the time of inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage may be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have the referral faxed to our office prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from date of service rendered.
- If you misrepresent your insurance you will be liable for any outstanding bills.

***I have read and understand the above Financial Policy and agree to meet all financial obligations.**

_____	_____	_____
Patient Name (please print)	**Patient Signature**	**Date**