

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 | <input type="radio"/> Yes | Asthma | <input type="radio"/> Yes | Seasonal allergies | <input type="radio"/> Yes |
| HIV | <input type="radio"/> Yes | High Blood Pressure | <input type="radio"/> Yes | Diabetes | <input type="radio"/> Yes |
| Gout | <input type="radio"/> Yes | Arthritis | <input type="radio"/> Yes | Anemia | <input type="radio"/> Yes |
| Seizures | <input type="radio"/> Yes | Heart murmur | <input type="radio"/> Yes | Phlebitis | <input type="radio"/> Yes |
| Artificial Valves | <input type="radio"/> Yes | Pacemaker | <input type="radio"/> Yes | Stroke | <input type="radio"/> Yes |
| Irregular heartbeat | <input type="radio"/> Yes | Hepatitis C | <input type="radio"/> Yes | Hepatitis B | <input type="radio"/> Yes |
| Lupus | <input type="radio"/> Yes | Artificial joint | <input type="radio"/> Yes | Heart Attack | <input type="radio"/> Yes |
| High Cholesterol | <input type="radio"/> Yes | Glaucoma | <input type="radio"/> Yes | Anxiety/Depression | <input type="radio"/> Yes |

Other organs

Details

Thyroid disease Yes _____

Kidney disease Yes _____

Bladder problems Yes _____

Stomach Yes _____

Bowel Yes _____

Cancer Yes _____

List any other diseases or conditions we should know about _____

List any surgical procedures in the last 6 months _____

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Name _____ Date of Birth _____

Without sunscreen you: tan only burn then tan burn only

Have you had skin cancers? Yes No If yes, what kind _____

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

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

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

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

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

What drug? _____

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

Occupation _____

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

Fever Yes Weight loss Yes Shortness of breath Yes

Fatigue Yes Vision change Yes Burning on urination Yes

Easy bruising/bleeding Yes Cough Yes Chest pain Yes

Muscle pains Yes Joint pains Yes Nausea, vomiting, diarrhea Yes

Runny nose Yes Depressed moods Yes Night sweats Yes

Headache Yes

Women: are you pregnant? Yes No Not sure Planning

Women: are you menstrual periods regular? Regular Irregular

Women: are you breastfeeding? Yes No

CENTER CITY DERMATOLOGY - REGISTRATION FORM – page 3

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / Partner	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> 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.: ()
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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

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

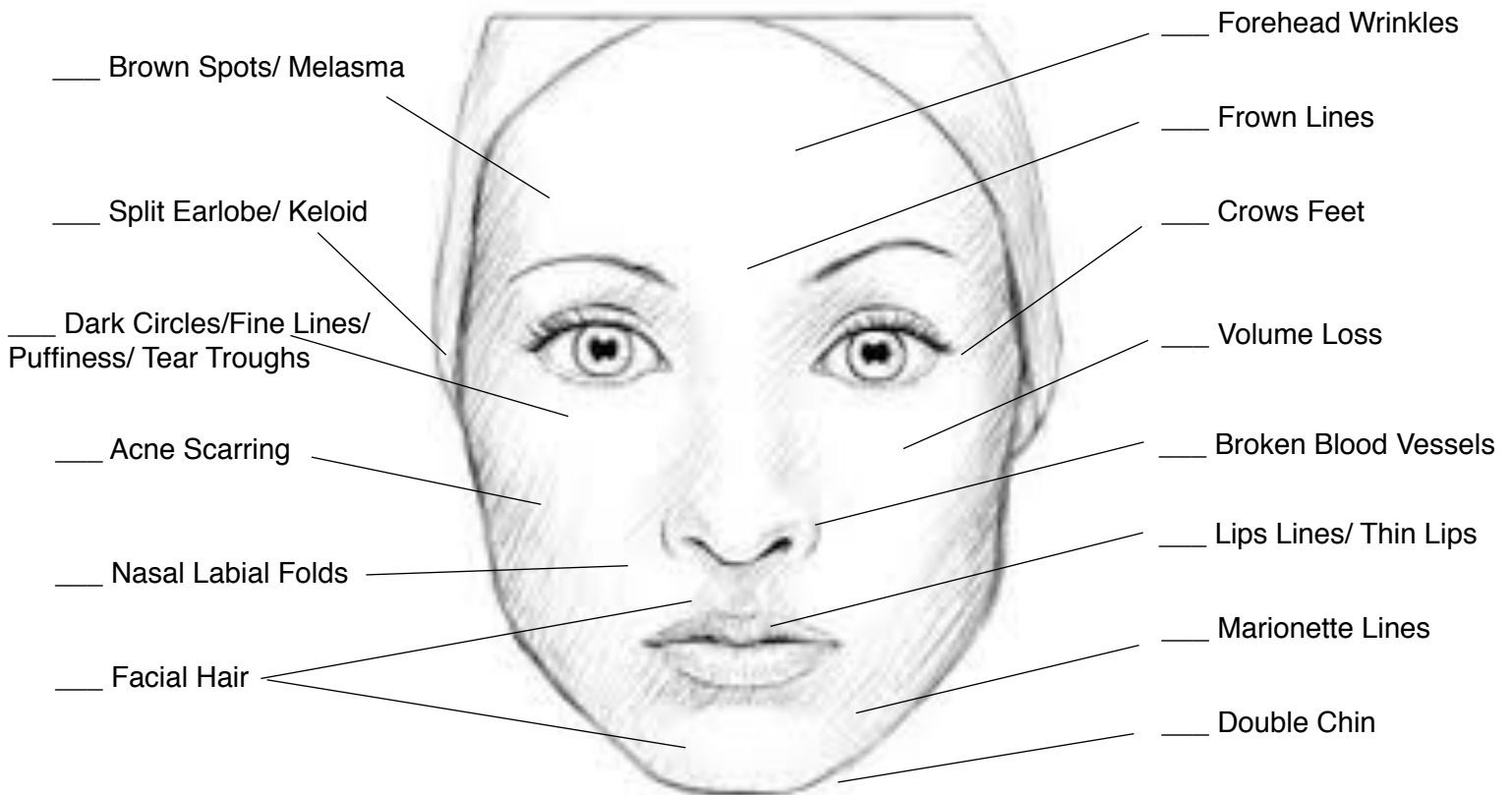
Cosmetic Interest Questionnaire

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)



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.

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

Patient Signature: _____ Date: _____