Alliance Dermatology & MOHS Center, P.C.
Patient Information

Patient Name: ____ Gender: M / F
Last First M.I.

Social Security Number: _____ / _____ / _____ Date of Birth: _____ / _____ / _____
*(If you elect **not** to provide your social security number, you **must** sign the waiver on the bottom of this page.)*

Address: ____
Street / PO Box Unit # City State Zip Code

***Secondary Address (For Part-time Residents): ____
Street / PO Box City State Zip Code

Home#: (_____) __________________ Work#: (_____) __________________ Cell#: (_____) __________________

Marital Status, (Please Circle): S M W D Separated

Employer: ____________________________ Email Address (**See disclaimer below):______________________________

Primary Physician: ____ Phone#: ______________________

Referring Physician: ____ Phone#: ______________________

If not referred by a physician, how did you hear about us?: __________________________________

Emergency Contact Information

Emergency Contact: ____ Phone#: ______________________

Relationship to patient: ________________________________

Insurance Information

Primary Policy Holder: ____ Gender: M / F
Last First M.I.

Relationship to patient, (Please Circle): S elf Parent Spouse Other

Social Security Number: _____ / _____ / _____ Date of Birth: _____ / _____ / _____
*(If you elect **not** to provide your social security number, you **must** sign the waiver on the bottom of this page..)*

Address: ____ Phone#: ______________________
Street / PO Box City State Zip Code

Employer: ________________________________

Primary Insurance: ___________________________ Secondary Insurance: ___________________________

Authorization to release information and assignment of benefits and office policies***

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary for my insurance to pay the claim. I understand that I am responsible for all charges incurred and that if this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. Please be advised that if a biopsy is performed, the specimen(s) will be sent to an outside laboratory for either slide preparation and/or pathology readings. This laboratory has its own set of fees and you will receive a bill from their facility. If you have any questions regarding this bill, please contact the laboratory directly. Please be advised that no insurance company guarantees payment and you will be responsible for any charges your insurance company denies. Additionally, by providing my email above, I understand I am agreeing to receive promotional emails through way of email from both Alliance Dermatology and Dermatologist's Choice. By signing below, I acknowledge that I have read and understand the office policies and procedures:

Patient or Parent/Guardian Signature: ____ **Date:** ________________

Notice of Privacy Practices Acknowledgment

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information be kept properly confidential. "HIPAA" policies are outlined in detail on the attached form, and a copy of the attached for is also available for your records upon request. By signing below I acknowledge that I understand the "HIPAA" policy and may receive a detailed explanation at any time:

Patient or Parent/Guardian Signature: ____ **Date:** ________________

Waiver for *nondisclosure* of Social Security Number

I elect not to provide my social security number, due to identity theft concerns or other reasons. I understand that it is also my right not to have to disclose it. However, if my insurance company should deny payment of a claim due to lack of SSN, then I will be responsible for the claim and/or dealing with my insurance company for payment.

Patient or Parent/Guardian Signature: ____ **Date:** ________________

Medical Questionnaire

Patient Name: ____ **Date:**______________

Reason for today's visit: ____

Do you have a pacemaker?: Yes / No   Do you smoke?: Yes / No   Do you drink?: Yes / No

(Female patients) Are you pregnant?: Yes / No

Have you had any surgeries in the last five years? If yes, please explain: ________________________________

Please list any medications you are allergic to: ____

Are you allergic to epinephrine? Yes or No   Are you allergic to latex? Yes or No

Please indicate if you are currently taking any medications: **(****We can copy a list if you have one available****)**

RX: __________________ Reason: _______________ RX: __________________ Reason: _______________

RX: __________________ Reason: _______________ RX: __________________ Reason: _______________

RX: __________________ Reason: _______________ RX: __________________ Reason: _______________

RX: __________________ Reason: _______________ RX: __________________ Reason: _______________

Do you have any of the following medical conditions?:

___ Allergies
___ Arthritis
___ Asthma
___ Depression/Anxiety
___ Diabetes, Circle type: Type 1 - Type 2
___ Heart Problems
___ Hepatitis, Circle type: B or C
___ High Cholesterol
___ High Blood Pressure
___ HIV or AIDS
___ GI Disorder
___ Seizure Disorder
___ Stroke
___ Other, Please list:_____________

___ History of cancer – NOT Skin, Please list type: ____

___ History of skin cancer (Please circle type): Basal-cell Carcinoma Squamous-cell Carcinoma Melanoma

Does an immediate family member have any of the following medical conditions?
****Immediate family members include: Father, Mother, Sibling, or Child****

___ Allergies
___ Arthritis
___ Asthma
___ Depression/Anxiety
___ Diabetes, Circle type: Type 1 - Type 2
___ Heart Problems
___ Hepatitis, Circle type: B or C
___ High Cholesterol
___ High Blood Pressure
___ HIV or AIDS
___ GI Disorder
___ Seizure Disorder
___ Stroke
___ Other, Please list:_____________

___ History of cancer – NOT Skin, Please list type: ____

___ History of skin cancer (Please circle type): Basal-cell Carcinoma Squamous-cell Carcinoma Melanoma

Consent for Treatment

Knowing that I am suffering from a condition requiring diagnostic, medical, or surgical treatment, I do hereby voluntarily consent to such procedures and care and to such medical, surgical, or other services under the general and special instructions of Richard G. Bottiglione, MD, S. Sasha Jazayeri, MD, assistants, designee, or other doctor as is judged necessary. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment or examination by Richard G. Bottiglione, MD and/or S. Sasha Jazayeri, MD. Anyone who receives an injection of any kind, procedure of any kind, biopsy, or surgery may have the possibility that it will result in a brown, red, white, or depressed scar appearing in the area. I understand that the potential risks and benefits of surgery include risk of infection, bleeding, injury to nerves, postoperative stiffness and pain, and failure of the surgery to achieve its intended goals. An infection is usually very swollen skin, which should be reported to the office immediately. I give consent for any pictures to be taken for medical documentation purposes. I also acknowledge that treatments including, chemical peels (TCA Solution), may result in redness, dryness, peeling skin, and possible chemical burns, which should improve over time. Please be advised that if you do not wish to sign this consent form, the doctor(s) and/or their assistant(s) will not be able to treat you for any condition.

Patient or Parent/Guardian Signature: ____________________________________ **Date:** _______________

*****Medical Records Release*****

I hereby give consent for Alliance Dermatology to disclose my medical information to the below listed person(s). I am aware that by signing this consent, any and all medical information may be discussed with the person(s) I designate. This consent will remain in effect until otherwise requested in writing.
Please list any person(s) that you give permission for Alliance Dermatology to release your medical information to:

Name: ____ Relationship to patient: _________________

Name: ____ Relationship to patient: _________________

Patient or Parent/Guardian Signature: ____