Alliance Dermatology & MOHS Center

S. Sasha Jazayeri; MD/Richard Bottiglione; MD

Patient Information

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

Social Security Number: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

Address: _____
Street / PO Box City State Zip Code

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

Marital Status, (Please circle one): S M W D Separated Race: Non-Hispanic/Non-Latino or Hispanic/Latino or Declined

Ethnicity: African American/ American Indian/ Asian/ Caucasian/ Other/ Decline Language primarily spoken:_____

Employer Name: _____ Employer Address: _____

Primary Physician: _____ Referring Physician: _____

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.

Social Security Number: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

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

Relationship to Patient, (Please Circle): Self Parent Spouse Other

Primary Insurance Name: _____ Secondary Insurance Name: _____

Notice of Privacy Practices Acknowledgement

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program as detailed at length in the attached form. By Signing below I acknowledge that I understand the "HIPAA" policy and may receive a detailed explanation at any time upon request to keep for my records.

Patient or Parent/Guardian Signature: _____

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: _____

Do we have permission to leave a message regarding your medical information on your answering machine or voicemail? Yes/No

Patient Signature: _____ **Date:**_____

Authorization to release information and assignment of benefits:

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. I have read and understand the office policy and procedures.
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 or concerns regarding this bill, please contact the laboratory directly; the phone number should be printed on your bill.

Patient or Parent/Guardian Signature:_____ **Date:**_____

Medical Questionnaire

Patient printed name:_____ Date of birth:_____

Please list all the medications you are currently taking including: prescriptions, over-the-counter medications, vitamins, and herbal supplements: (**We can copy a list if necessary**)

RX: _____Dosage: _____ RX: _____ Dosage: _____

RX: _____Dosage: _____ RX: _____ Dosage: _____

RX: _____Dosage: _____ RX: _____ Dosage: _____

RX: _____Dosage: _____ RX: _____ Dosage: _____

Please list any medications you are allergic to: _____

What reaction to you have to these medications:_____

Please list any surgical procedures in the last 5 years: _____

_____

Do you have a pacemaker? Yes / No Do you currently smoke? Yes / No Have you smoked in the past? Yes / No

Do you drink alcohol? Yes / No How many alcoholic drinks per week? _____

(Female Patients) Are you pregnant? Yes / No What pharmacy do you prefer? _____

Do you have, (or have you had), any of the following medical conditions?

☐ Allergies	☐ Heart problems	☐ Do you bleed easily?
☐ Arthritis	☐ High blood pressure	☐ Problems with healing
☐ Seizure disorder	☐ High Cholesterol	☐ Tendency to scar/form keloids
☐ Asthma	☐ Diabetes	☐ HIV or AIDS
☐ Artificial joint(s)	☐ Depression/Anxiety	☐ Eczema/Rash from bandages or adhesive
☐ Asthma/Lung Disease	☐ Cancer	☐ Hepatitis, Circle type: B or C
☐ GI disorders	☐ Stroke	☐ Other, Please list: _____

☐ 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: F=Father, M=Mother, SO=Son D=Daughter, B=Brother, S=Sister ***

____ Allergies	____ High Cholesterol	____ Eczema/Rash from bandages or adhesive
____ Arthritis	____ Seizure disorder	____ High blood pressure
____ Asthma	____ Stroke	____ Heart problems
____ Artificial joint(s)	____ Diabetes	____ GI disorders
____ Asthma/Lung Disease	____ HIV or AIDS	____ Depression/ Anxiety
____ Cancer	____ Hepatitis, Circle type: B or C	

____ History of skin cancer (Please circle type): ◯Basal-Cell Carcinoma ◯Squamous-Cell Carcinoma ◯Melanoma

Consent for Treatment

Knowing that I am experiencing a condition that may require 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 S. Sasha Jazayeri, MD, Richard Bottiglione, 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 S. Sasha Jazayeri, MD and/or Richard Bottiglione.
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 the 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. In the event that Alliance Dermatology finds it important to share certain medical information with your Primary Care Provider you consent us to doing so.

Patient or Parent/Guardian Signature: _____