How did you hear about us? ________________

Cosmetic Medical History

Name ________________________________ Date of Birth __/__/__ Today's Date__/__/____

Reason for today's visit: ____

Please circle your cosmetic concerns:

Sun spots / Age Spots	Wrinkles	Birthmarks- Brown/Red
Spider veins Face	Telangiectasia	Red spots- cherry angiomas
Hyperpigmentation	Rosacea	Leg Veins
Acne Scars	Large pores	Actinic Keratoses / Precancers
Surgical scars	Hypertrophic scars	Laser Hair removal
Sagging Skin	Lines around mouth/eyes	Discuss Skin care regimen

Previous Cosmetic Treatments/Surgeries*____

____

What current skin care products are you using? ____

Are you allergic to any medications, including skin related allergies? □ Yes □ No

If yes, which medication? ____

Have you ever had an allergic reaction to anesthesia/injections? □ Yes □ No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, herbals):

____

____

Are you pregnant, nursing, or planning a pregnancy soon? □Yes □ No ______________________

Have you ever had skin cancer? □Yes □ No If yes,____

Has anyone in your family had skin cancer? □Yes □No

Do you have a history of any specific skin diseases? □ Yes □ No If yes,_______________________

Do you have problems with healing? □ Yes □ No

Do you develop keloids (scars) after surgery? □ Yes □ No If yes,__________________________________

Do you bleed easily? □ Yes □ No

Do you develop skin rashes in reaction to □Medications □ Food □Environment □ Bandages □ Topical Neosporin □ Other _

____

Do you smoke? □Yes □ No If yes, how much: ____________________________

□Current Smoker □Former Smoker □Never Smoked

Do you drink? □Yes □ No If yes, __________________ drinks per day

Have you had or have been exposed to HIV (AIDS), Hepatitis A, B, or C? □ Yes □ No

If yes, ____

Have you ever had cold sores or fever blisters? □ Yes □ No

When was last breakout? _________________

What is your occupation? ________________________________Hobbies? _______________________

Mark your skin type (when exposed to the sun for about 1 hour with no protection):

Skin Type	**Skin Color**	**Characteristics**
I	White; very fair; red or blond hair; blue eyes; freckles	Always burns, never tans
II	White; fair; red or blond hair; blue, hazel, or green eyes	Usually burns, tans with difficulty
III	Cream white; fair with any eye or hair color; very common	Sometimes mild burn, gradually tans
IV	Brown; typical Mediterranean Caucasian skin	Rarely burns, tans with ease
V	Dark Brown; mid-eastern skin types	very rarely burns, tans very easily
VI	Black	Never burns, tans very easily

When did you last get a tan? ______________________________

Do you wear a sunscreen daily? □ Yes □ No

Do you use chemical (sunless) sun tanning lotions? □ Yes □ No
Do you have any upcoming social events? □ Yes □ No If yes,______________________________

Patient Signature __________________________________ Date _____________

Reviewed by __________________________ Date ______________

Dermatology Specialists

REGISTRATION SHEET – PLEASE COMPLETE

Last name ________________________
First name___________________MI___
(As printed on Insurance card if applicable)

Primary Care Physician _______________________
Telephone # of PCP__________________________
Referring Provider__________________________
Date of birth________________________________

Sex: M or F

Address line 1______________________
Address line 2______________________
City______________________________
State ___________ Zip_______________
Home phone________________________
Cell phone__________________________
Work phone_________________________
Preferred pharmacy_________________

Email address_____________________
(for DSB purposes only will not be shared)

Marital status: S/ M/ W/ Partner
Social Security #____________________________
Employer name_____________________________
Race/Ethnicity ______________________________
Preferred Language ___________________________
How did you hear about us?
Other Patient ______ Referral ________ Ad_______
Emergency contact__________________________
Phone #*:* __________________________________
Relationship to Patient:______________________

Primary Insured Responsible Party (Fill out this portion if different from Self)

Name: Self / Other Named _____________________________MI: ______ DOB_______________
Address:_____________________________City_____________State___________Zip____________
Telephone #:_______________________________Relationship to Pt__________________________
Subscriber # ____________________________ Group #:__________________________________

INSURED RESPONSIBILITY: It is understood that services rendered by DS are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of DS to collect from the insurance company. We do this as a service to our patients.

PATIENTS: I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or is pre-existing, that I am responsible to promptly pay the balance in full.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All returned checks (NSF, Account Closed, Refer to Maker, or Uncollected Funds) are subject to a $40 service charge and cost of collection fee. In consideration of any services rendered by DS, or associated health care provider, I agree to be responsible for the payment of all services notwithstanding any insurance coverage I may have. If it is necessary for DS to employ anyone, including collection agencies and attorneys, to collect such payments, then I shall be responsible to pay reasonable fees and costs, as well as a $25 surcharge, in addition to said payment.

I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to any referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to DS.

Do we have your permission to:

1) Is it ok to leave a detailed message? Yes ___ No ___ Preferred # Home _________________ Cell_____________________
2) Discuss your medical condition with any member of your family? If yes Whom? _________________Relationship:______________
Whom? _________________Relationship:______________

In signing this document, I am attesting that I have read the above and that I have had all of my questions answered to my satisfaction.

____ ____________________________________

PATIENT SIGNATURE/LEGAL GUARDIAN DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Insurance Authorization And Assignment, I hereby authorize Dermatology Specialists to furnish information to insurance carriers concerning my diagnosis and treatments and I hereby assign to the physicians all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance and all collections costs should this account be assigned for collection. I accept and understand the responsibility of notifying DS of any requirement by my insurance company of pre-authorization prior to any surgical procedure. I understand that if I fail to get a referral, if necessary, I will be responsible for the charges.

Patient Name ______________________________

Relationship to Patient ______________________________

Signature ______________________________

Date ______________________________

FOR OFFICE USE ONLY

This consent was signed in front of ______________________________

T 303-442-6647 F 303-442-2696 WWW.DSDERM.COM

Cancellation and No-Show Policy for Providers

We schedule our appointments so that each patient receives the right amount of time and attention from our providers. As a courtesy, and to help patients remember their scheduled appointments, Dermatology Specialists sends out multiple reminders (via call, text and email) in advance of your appointment time. If your schedule changes and you cannot keep your appointment, please let us know via a phone call during regular business hours of 8am-4:30pm Monday-Friday at 303-442-6647 or by sending a text message to our main number at 303-442-6647 by 10am the business day PRIOR to the scheduled time to avoid being charged a no-show fee. Monday appointments need to be cancelled by 10am the Friday before the appointment is scheduled. Patients who do not show up for their appointment or do not provide the proper notification by cancelling their appointment by 10am on the prior business day will be charged a $75 no-show fee. This fee is NOT covered by insurance and must be paid in full by the patient prior to scheduling their next appointment. Please note that a continued history of no-shows or cancellations with less than 1 business days' notice may result in dismissal from Dermatology Specialists.

Cancellation and No-Show Policy for Estheticians

Effective June 9, 2023. Dermatology Specialists will be requiring patients to keep a card on file when scheduling all esthetician appointments. If the patient does not cancel/reschedule their appointment by 10am the prior business day or if they no-show for their appointment, a $75 no-show/cancellation fee will be charged to the patient's card on file. Monday appointments need to be cancelled by 10am the Friday before the appointment is scheduled. These "no-show charges" are not reimbursable by your insurance company, and you will be charged directly. Please note that a continued history of no-shows or cancellations with less than 1 business days' notice may result in dismissal from Dermatology Specialists.

I have read and understand the Cancellation and No-Show Policy for Dermatology Specialists.

Patient/Guardian Signature: ________________________________ Date: ____________

Printed Patient Name/Guardian: ____________________________ DOB: ____________