Center for Advanced Aesthetics

Patient Registration Form

Today's Date: ______________________

Patient's Last Name ______ First Name ______ Middle Name ______

Nickname ______ Date of Birth (MM/DD/YYYY) ______ Sex ______

Preferred Language ______ Race ______ Ethnic Group ______

Mobile Phone ______ Home Phone ______ Work Phone ______

Email address ______

Preferred Phone: ☐ Home ☐ Mobile ☐ Work
Preferred Contact Method: ☐ Phone ☐ Email ☐ Patient Portal

Mailing Address (inc. Apt. #) ______ City ______ State ______ Zip ______

Occupation ______ Employer/School ______ Employer/School Phone ______

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: ______

Spouse's Name ______ Phone ______ Occupation/Employer ______

Emergency Contact Name ______ Emergency Contact Phone ______ Relationship to Patient ______

Caretaker Name ______ Phone ______

Responsible Party/Guarantor (if other than patient)

Name ______ Date of Birth ______ Relation to Patient ______

Address ______ City ______ State ______ Zip ______

Primary Phone Number ☐ Home ☐ Mobile ☐ Work
Secondary Phone Number ☐ Home ☐ Mobile ☐ Work

Referral Information (Please check below to help us determine how you heard about our office)

☐ Physician ☐ Friend ☐ Relative ☐ Insurance ☐ One of our patients ☐ Our website ☐ Prior patient ☐ Referral service

☐ Internet (specify search engine): ______ ☐ Other: ______

Referring Physician (Name, Address) ______ Phone Number ______

Primary Care Physician (Name, Address) ______ Phone Number ______

Preferred Pharmacy (Name, Address inc. City & Zip) ______ Phone Number ______

In-Network Lab ______ Phone Number ______

Information Release

Do you give our office permission to discuss your medical information with family members, Including but not limited to: biopsy results, blood/lab results, or other test results?

☐ Yes (explain):
☐ No

Name ______ Relationship ______ Phone Number ______

Signature (Patient or Legal Representative) ______ **Date** ______

Center for Advanced Aesthetics

Patient Health History Form

Today's Date: ______________________

Reason for Visit

____

____

____

Medical Alerts

- Do you develop keloid scars? ☐ Yes ☐ No
- Are you on blood thinners (bleed easily)? ☐ Yes ☐ No
- Do you have an artificial heart valve? ☐ Yes ☐ No
- Have you had Artificial Joints in the last 2 years? ☐ Yes ☐ No
- Do you have a Defibrillator or Pacemaker? ☐ Yes ☐ No
- Do you have history of MRSA infection? ☐ Yes ☐ No
- Do you require antibiotics prior to procedures? ☐ Yes ☐ No
- Do you develop rapid heartbeat to epinephrine? ☐ Yes ☐ No

Past Medical History

Have you ever had any of the following?

☐ NOT APPLICABLE	☐ Bone Marrow Transplant	☐ Diabetes	☐ HIV/AIDS	☐ Leukemia
☐ Anxiety	☐ Breast Cancer	☐ End Stage Renal Disease	☐ High Blood Pressure	☐ Lung Cancer
☐ Arthritis	☐ Colon Cancer	☐ GERD (Acid Reflux)	☐ High Cholesterol	☐ Lymphoma
☐ Asthma	☐ COPD	☐ Hearing Loss	☐ Hyperthyroidism	☐ Prostate Cancer
☐ Atrial Fibrillation	☐ Coronary Heart Disease	☐ Heart Valve Replacement	☐ Hypothyroidism	☐ Seizures
☐ BPH (Enlarged Prostate)	☐ Depression	☐ Hepatitis	☐ Joint Replacement	☐ Stroke

Other: ______________________

Hospitalizations & Surgeries Attach list if needed.

______________________ Reason ______________ Date

______________________ Reason ______________ Date

Skin History

Have you ever had any of the following:

☐ Acne	☐ Dry Skin	☐ Moles (canerous)
☐ Actinic Keratosis	☐ Eczema	☐ Poison Ivy
☐ Asthma	☐ Flaky/Itchy Scalp	☐ Psoriasis
☐ Basal Cell Carcinoma	☐ Hay Fever/Allergies	☐ Squamous Cell Carcinoma
☐ Blistering Sunburn	☐ Melanoma	

If you have had skin cancer (basal cell, squamous cell, or melanoma), please provide additional details:

Year? ____________ Body location? ____________________

How was it treated? ______________________________

Do you have a family history of melanoma? ☐ Yes ☐ No

Do you regularly apply sunblock to exposed areas? ☐ Yes ☐ No

If yes, which SPF? __________ Is it zinc-based? ☐ Yes ☐ No

Have you visited tanning salons or do you sunbathe? ☐ Yes ☐ No

During your visit today, would you like to learn about skin cancer treatments and/or products to optimize the health and appearance of your skin? ☐ Yes ☐ No

Social & Other (REQUIRED)

Have you ever smoked/used tobacco? ☐ Yes ☐ No

# of years ______________________ # of packs/day __________

Do you smoke/use tobacco now? ☐ Yes ☐ No

# of packs/day __________

Do you use recreational drugs? ☐ Yes ☐ No

Types? ______________________ # of times/week __________

Have you ever received the pneumonia vaccine? ☐ Yes ☐ No

Do you have a **Healthcare Proxy** in the event you cannot make your own medical decisions? ☐ Yes ☐ No

Do you have a **Living Will**? ☐ Yes ☐ No

Women Only

Are you pregnant, breastfeeding, or planning to become pregnant? ☐ Yes ☐ No

Current Medications Attach list if needed.

List all medications you are currently taking (including prescriptions, vitamins, herbals, over-the-counter, and birth control pills or devices)

If none, please check here: ☐

Name	Dosege	Frequency

Allergies Attach list if needed.

Are you allergic to any of the following? ☐ No

☐ Adhesive Tape	☐ Asprin	☐ Latex
☐ Codeine	☐ Sulfa	☐ Lidocaine
☐ Penicillin	☐ Cephalexin	☐ Clindamycin

Do you have any other medication allergies? ☐ No

Name	Reaction

Family History

Has anyone in your family ever had any of the following conditions?

☐ Anormal Moles	☐ Asthma	☐ Psoriasis
☐ Acne	☐ Cancer	☐ Skin Cancer (not melanoma)
☐ Allergies	☐ Diabetes	☐ Other: __________
☐ Arthritis	☐ Eczema	☐ No

______________________________ ______________

Signature (Patient or Legal Representative) **Date**

______________________________ ______________

Printed Name of Signer **Patient's DOB**

Center for Advanced Aesthetics

Patient Agreements

Consent to Treatment

☐ **Consent to Photography**
I authorize Shah Dermatology, LLC and its agents to use photography to enhance my medical record. My photograph or likeness will be part of the medical record and not used for any educational or promotional purposes or shared with any other third party without my written consent. The use of these photos is strictly for medical record keeping.

☐ **Consent to In-Office Procedures**
I voluntary give my consent for treatment and also my consent to any procedure that my provider performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridgement of wounds, injections of skin lesions, cauterizations of skin lesions, surgery/electro cautery. I understand that my provider will discuss in d tail any procedure he/she plans to perform, answer all questions relating to the procedure and obtain oral informed consent in the exam room.

Agreement to Office Policies

My signature below indicates that I have read, understand, and will comply with the information contained within the practice's Office Policies (last revised January 2, 2024). I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time. For your convenience, a copy of this form is available on our website for your review.

Signature of Patient (or Legal Representative)

Date

Print Name of Patient

Print Name of Legal Representative (if applicable)

Acknowledgement of Receipt & Consent to Notice of Privacy Practices

My signature below indicates that I have reviewed, acknowledge, and consent to the information contained within the pratice's Notice of Privacy Practices (last revised January 2, 2024). I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time. For your convenience, a copy of this form is available on our website for your review.

Signature of Patient (or Legal Representative)

Date

Print Name of Patient

Print Name of Legal Representative (if applicable)

Center for Advanced
Aesthetics

Office Collections Acknowledgement & Authorization

Thank you for choosing Shah Dermatology, LLC for your healthcare needs. To help us fulfill our mission to provide personalized and exceptional care to each of our patients, we have developed office collections policies to create a productive relationship between you and our team of providers.

This form[1] outlines our office & financial procedures for patients:

- If you are insured, please provide us with your most current plan information, including any secondary, supplemental, or additional coverage. Please bring your insurance card and photo ID with you to each visit, we are required to confirm your identity when you check-in.
- As a courtesy, our office will verify your insurance network, eligibility, and benefits prior to your scheduled appointment; however, it is ultimately your responsibility to confirm that your coverage is active and in-network and that services provided by our office is covered by your insurance plan.
- If you are not insured, or if we are not in-network with your insurance, payment in full for services provided are due at the time of service.
- **Please review your insurance benefits and coverage prior to each visit so that you understand your financial obligations for specialist encounters.** Because there is no guarantee of reimbursement or payment from any insurance company or payer, you agree to pay all charges for your treatment not paid by your insurer or any other payer source. **Pursuant to our contractual terms with your insurance payer(s), we will collect any applicable copayment, deposit[2] toward deductible and/or coinsurance, and outstanding balance at each visit**, and any remaining charges are due and payable upon receipt of the bill.
- Once your insurance company processes the claim for your visit and determines your financial responsibility based on your benefit coverage (“Patient Responsibility”), your insurance company will send you an explanation of benefits (EoB). Our office will apply any applicable payments and/or deposits toward your financial responsibility. If a balance remains, our office will contact you by sending an initial statement to your mailing address on file.
- Statements and payment information can be accessed through your activated patient payment portal. You will receive an account credit or refund[3] for any overages paid at the time of service.
- You may pay your outstanding balance **within 25 days of the date on your initial statement** (“Statement Date”) with your preferred payment method. If you do not pay your balance in full within 25 days of the Statement Date or directly contact our billing department to request alternate payment arrangements.

My signature below indicates that I have read, understand, and will comply with the information contained in this Office Collections Acknowledgement & Authorization.

Signature of Patient (or Legal Representative) ____________________

Date ____________________

Print Name of Patient ____________________

Print Name of Legal Representative (if applicable) ____________________

[1] This form incorporates by reference our Office Policies and replaces any previously signed Office Collections Acknowledgement & Consent or Authorization forms.
[2] Deposit amounts are set forth in our Office Policies and are subject to change as our office deems necessary and appropriate.
[3] Any credit balance will first be applied to any outstanding or upcoming balance. If the remaining credit balance is less than $5.00, our office will mail a refund check ony upon request within 180 days of your date of service.

St. Mary’s Medical Center (Charlotte Hall) 37767 Market Drive, Suite 200 | Charlotte Hall, MD 20622 **P** 301.884.0278 **F** 301.884.8663
J.P. Jarboe Medical Center (California) 22590 Shady Court, 3rd Floor | California, MD 20619 **P** 301.994.8010 **F** 301.373.9197
MedStar Shah Medical Center (Waldorf) 10 St. Patricks Drive, 3rd Floor | Waldorf, MD 20603 **P** 240.448.2970 **F** 301.638.7257

www.shahdermatologyLLC.com

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