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SKINSMART
DERMATOLOGY
 Elizabeth S. Callahan, MD

Cosmetic Dermatology
MOHS Surgery
Medical Dermatology

www.sarasotadermatologist.com

Patient Legal Name		Date of Birth	Age	Sex	Social Security Number (REQUIRED)	
Primary Address		City	State		Zip Code	Home () Work () Cell ()
Summer Address		City	State		Zip Code	Home
If Minor, Legal Guardian's Name						
Emergency Contact		Relationship		Emergency Contact Number		

Uninsured method of payment: <input type="checkbox"/> Cash <input type="checkbox"/> Credit (Visa, Amex, MasterCard) <input type="checkbox"/> CareCredit			
Primary Insurance: _____		Secondary Insurance: _____	
Subscriber ID:	Insured's Name	Subscriber ID:	Insured's Name
Relationship to Patient	Date of Birth	Relationship to Patient	Date of Birth
Name of Primary Care Physician			
		Phone:	Fax:
Name of Referring Doctor			
		Phone:	Fax:

How did you hear about our office? (Please check all that apply)	<input type="checkbox"/> Doctor _____	<input type="checkbox"/> Internet	<input type="checkbox"/> Phone Book
	<input type="checkbox"/> Patient _____	<input type="checkbox"/> Magazine	<input type="checkbox"/> Drive-By
	<input type="checkbox"/> Insurance/Insurance Website	<input type="checkbox"/> Seminar	<input type="checkbox"/> Staff
	<input type="checkbox"/> Physician's Guide	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Other _____
<input type="checkbox"/> Yes, I wish to receive occasional SkinSmart Dermatology news and service/product updates. Email Address: _____			
<small>SkinSmart does not sell, share, rent, or disclose your information as it is for internal office use only. By checking the box, you give us permission to add you to our mailing list.</small>			

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to Elizabeth F. Callahan, MD or SkinSmart Dermatology. **Any pathology and laboratory fees are billed independently of SkinSmart Dermatology and are ultimately the patient's responsibility.**

Payment is required for all services at the time they are rendered. **All applicable co payments and deductibles will be collected at the time of service.** Our terms are net 30 days. Appointments that are not cancelled 24 hours prior to the appointment time may be charged a \$25 fee. Your signature below signifies your understanding and willingness to comply with this policy.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, copays, coinsurances and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of service provided.

Signature of Patient or Legal Guardian _____ Date _____

Patient _____ DOB _____ Age _____ Today's Date _____

Reason for your visit today: _____

List all medications you are currently taking, including over the counter medications, vitamins, and natural or holistic remedies. Include Dose and how often you take it.

Please list all Allergies to Medicines:

Medication: _____ Reaction: _____

Do you need antibiotics prior to having dental cleanings? No Yes If so, why _____

Please check yes or no of appropriate box of medical conditions you had or currently are experiencing (attach sheet if necessary):

	YES	NO		YES	NO
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
History of Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Bowel	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

Please list any skin cancers and location(s): _____

Please list any other diseases or conditions: _____

Major surgeries by date in the last 5 years: _____

Hospitalizations in the last 5 years: _____

Social History: Occupation: _____

Do you smoke? No Former Yes: How many packs per day? _____

Do you drink? No Former Yes: How many drinks per day? _____

Women ONLY: Are you pregnant? Yes No Trying to get pregnant? Yes No Breast feeding? Yes No

Are you on Birth Control? Yes No Are you post menopausal? Yes No

Family History: Melanoma: who? _____ Basal or Squamous cell skin cancer: who? _____

X _____ Date _____ X _____ Date _____
Signature of Patient Date Signature of Medical Provider Date

MOHS Consultation Patients ONLY

Location of the growth to be removed? _____ Is it growing? Yes No

How long has the growth been present? _____ How the growth been treated previously? _____

Does the growth do the following: **Bleed?** Yes No **Ulcerate?** Yes No **Tingle?** Yes No

Do you have a history of: **X-Ray treatments for acne** Yes No **Chronic Scarring** Yes No

Immunosuppression Yes No

SKINSMART DERMATOLOGY

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HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:

Printed Name: Patient or Representative

Signature

Date

Relationship to Patient (if other than patient)

SKINSMART DERMATOLOGY

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Release of Information

May we leave personal medical information on your answering machine at home? Yes No

May we leave personal medical information on your cell phone voicemail? Yes No

Do you give our office permission to discuss your medical information with family members? Yes No

If yes, please provide their name and phone number below.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Signature of Patient or Patient Representative

Date

SkinSmart Dermatology

Cosmetic/Skin Care Interest Questionnaire

We offer a wide range of services with our dermatologist, nurse practitioner, and paramedical esthetician. If you would like more information about our services, please complete the following form and return to the front desk so that we may best serve your needs.

Patient Name: _____ Date: _____

For the following statements, please circle the number that best reflects your opinion with 1 being the least and 5 being the most.

I would like to improve the condition and appearance of my skin.

1 2 3 4 5

When looking at my face in the mirror, I believe I look older than my true age.

1 2 3 4 5

If effective, I would be interested in non-surgical options to successfully correct my lines & wrinkles.

1 2 3 4 5

Cosmetic concerns and procedures or products of interest to you (please check all that apply).

- | | | |
|---|---|---|
| <input type="checkbox"/> BOTOX® Cosmetic | <input type="checkbox"/> Skin Care Advice | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Age Spots/Photofacial | <input type="checkbox"/> Sun Damage/Brown Spots | <input type="checkbox"/> Spider vein treatments |
| <input type="checkbox"/> Eyebrow enhancement | <input type="checkbox"/> Mineral Make-up | <input type="checkbox"/> Laser Resurfacing |
| <input type="checkbox"/> Anti-Cellulite Treatments | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Dermaplaning |
| <input type="checkbox"/> Medical Grade Eyelash Enhancer | <input type="checkbox"/> Skin Care Products | <input type="checkbox"/> Permanent Hair Removal |
| <input type="checkbox"/> Facial vein treatment/Birthmarks | <input type="checkbox"/> Corrective Skin Care | <input type="checkbox"/> Facials |
| <input type="checkbox"/> Dermal Fillers (Juvéderm, Restylane) | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Sunscreen Advice |
| <input type="checkbox"/> Other, please specify _____ | | |

I would like to be contacted for further information, events & promotions; the best way to contact me is:

Mail Phone Email: _____

Signature: _____

Thank You!

***Make your SkinSmart experience complete with a complimentary mineral make-up application with our paramedical aesthetician. Simply check with our front desk for availability.*

Our thanks and sincere appreciation for sharing your thoughts & time with us! Please enter your name & email address for a chance to win our weekly give-away drawing.

Name: _____
Email: _____