ADVANCED DERMATOLOGY

Patient's Name: _____ Date of Birth: _____
Age:_____ Home Phone: (____)_____Work Phone: (_____)_____
Occupation: _____Referring MD: _____

Please state the main reason you are seeing the doctor: _____
_____
_____

Are you allergic to any medications: ( ) YES or ( ) NO If YES, Please indicate which one(s):_____
_____

Please list all medications you are currently taking. Include nonprescription medications and medications that you take only
occasionally:_____
_____

How much alcohol do you consume in a week? _____How much tobacco in a week?_____

Have you been previously diagnosed with, treated for, or received any of the following:
**( PLEASE CIRCLE YES or NO):

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV Infection | Y | N | Heart Pacemaker | Y | N |
| Arthritis/Gout | Y | N | High Blood Pressure | Y | N |
| Bleeding Disorder/Tendency | Y | N | Intestinal Colitis | Y | N |
| Blood Transfusions | Y | N | Kidney Disease | Y | N |
| Breathing Difficulties | Y | N | Liver Disease | Y | N |
| Cancer (other than skin) | Y | N | Psoriasis | Y | N |
| Cold Sores/Fever Blisters | Y | N | Psychiatric Illness | Y | N |
| Diabetes | Y | N | Scarring/Keliods | Y | N |
| Eczema | Y | N | Seizures | Y | N |
| Glaucoma | Y | N | Stomach Ulcers | Y | N |
| Heart Disease | Y | N | Stroke | Y | N |
| Heart Rhythm Disturbance | Y | N | Ultraviolet Light Treatments | Y | N |
| Heart Murmur | Y | N | Defibrillator | Y | N |
| Artificial Joints | Y | N | Artificial Heart Valve | Y | N |

Do you take antibiotics before undergoing dental procedures?_____

Skin cancer ( ) Yes or ( ) No If Yes, what type, location, year treated? _____
_____

Please list other illnesses, surgeries, hospitalizations & dates:_____
_____

Family History (hypertension, diabetes, cancer, etc):_____
_____

Completed by/ Signature:_____/_____ Date: _____
Physician
Signature:_____Date:_____

# ADVANCED DERMATOLOGY, L.L.C.

111 Salem Turnpike, Suite 7
Norwich, CT. 06360

## RELEASE OF INFORMATION AND AUTHORIZATION OF BENEFITS FORM

Patient Name: _____ (please print).
Account# _____

I authorize Advanced Dermatology, L.L.C. to release medical information, or anything pertaining to the examination, treatment, history, and medical expenses including pre-existing condition information to my insurance company(ies) and/or its acting intermediary or agent, or employer/compensation carrier(s), or its legal representative for the purpose of processing insurance claims. This release may include reviewing and/or photocopying pertinent documents for the purpose of payment by your insurance company.

I authorize release of medical information to physicians or health practitioners (for example, Physical therapists) to whom I may be referred.

I authorize payment of medical insurance benefits* to be made directly to Advanced Dermatology, L.L.C. I permit a copy of this authorization to be used in place of the original.

I agree to accept full financial responsibility for payment of charges for services rendered to the above patient. I understand that if Advanced Dermatology, L.L.C. does not participate with my insurance I will be responsible for all charges not paid by my insurance.

I further agree to pay the cost of collections and/or attorney's fees in the event this account is referred to a collection agency or attorney. Advanced Dermatology requires a 24-hour advanced cancellation notice, failure to notify the office will result in a $25.00 no show fee effective June 1, 2004.

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with an effective date of June 1, 2004.

_____

Patient or Guarantor Signature Date

_____

If guarantor, indicate relationship to patient

*For Medicare patients, this applies to The Social Security Administration or its intermediaries, or carriers.
*For Blue Shield of Connecticut, this applies to a covered service rendered by a participating physician only.

# Advanced Dermatology Patient Demographic Sheet

Date _____ Marital
Patient's Name: _____ Gender: ____ Status: S M W D

Date of Birth: _____ S.S. #: _____

Address: _____

City: _____ State: _____ Zip: _____

Tele #: Home: _____ Work: _____

Employer: _____

Family MD: _____ Referring MD: _____

Referring MD's Address: _____

**PLEASE FILL IN ALL INSURANCE INFORMATION BELOW:**

**Name of Primary Insurance Company**: _____

Identification#: _____Group# _____

Name of person who holds the insurance policy: _____

SS#: _____ Date of Birth: _____

Relationship to Patient: _____

**Name of Secondary Insurance Company**: _____

Identification#: _____Group# _____

Name of person who holds the insurance policy: _____

SS#: _____ Date of Birth: _____

Relationship to Patient: _____

** **Parent/Guardian:** Name and Address (if different than above):

_____Tele #:_____

Please list any spouse, family member, caregiver, and/or friend who Advanced Dermatology can speak with regarding your care, biopsy results, appointments, etc. If we may only speak with you, please cross this section out.

Name: _____Your Initials: _____

**Emergency Contact:** _____Tele #: _____

(Rev. 7-12-10 KD)