ADVANCED DERMATOLOGY, LLC

MEDICAL HISTORY UPDATE

Patient Name: _____ Date of Birth _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Primary Care Physician: _____

Referring Physician: _____

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

_____

Are you allergic to any medication: ( ) YES or ( ) NO
If YES, please indicate which one(s):

_____

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

_____

_____

Do you take antibiotics before undergoing dental procedures? _____

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

Any Artificial Joints	Yes	No
Artificial Heart Valve	Yes	No
Heart Murmur	Yes	No
Internal Defibrillator	Yes	No

Please list any illnesses, surgeries, hospitalizations since your last visit: _____

_____

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.

(Rev. 7-12-10 KD)