ADVANCED DERMATOLOGY
and LASER INSTITUTE of SEATTLE
MEDICAL and COSMETIC SKIN CARE

INTRODUCTIONS

"Legal" Name _____Preferred Name _____Today's Date_____

Address _____City/State/Zip_____

Phone - H(___)_____ W(___)_____Cell (___)_____

Email _____

Birthdate _____Age___ Sex: M/F Marital Status: Married ☐ Single ☐ Widowed ☐ Partner/significant other ☐

Employer _____ Job title? _____

Students - Please provide family's address for billing_____

Emergency Contact Person:_____ Best # to reach them _____

Relationship to patient:_____

**** Students & dependents – Please list below the person who holds the insurance, ie, father, mother, spouse (legal Name)****

Primary Insurance Coverage	**Secondary Insurance Coverage**
Insured Name _____	_____
Insurance Co. Name_____	_____
Insurance Co. Address _____	_____
City/ State/ Zip_____	_____
Subscriber ID #_____	Subscriber ID #_____
Group # _____SS#____ - ____ - _____	Group # _____SS#____ - ____ - _____
Birth date _____	Birth date_____
Employer_____	Employer_____

Acknowledgement:
To the best of my knowledge, the above information is correct. I will inform this office of any changes in medical coverage, and general information provided above. I acknowledge that not all services provided in this office are covered by medical insurance. It is my responsibility to educate myself on the insurance plan I have chosen and I am ultimately responsible for all charges.

Cancellation Policy: A missed appointment is a loss to 3 people: you the patient, the doctor and the patient who could have taken that spot. As a courtesy to our Clinic, we require 3 business days to change and/or cancel the appointment you made. There is a $75.00 cancellation fee for general appointments. For surgical or cosmetic procedures, the cancellation fee is 25% of the scheduled appointment, if a deposit was made to hold the spot, the deposit will be transferred to the cancellation fee.

Medical Records: I understand that photographs are required to be taken periodically throughout my medical and cosmetic treatments to document my initial presenting skin issues and to effectively monitor and compare initial skin presentations with changes made over time. These photographs become part of my medical records but are kept proprietary. I hereby consent with my signature below to have photographs taken for the above reasons and to be kept proprietary in my patient records.

Patient Signature _____ **Date** _____
(Parent or guardian if patient is a minor)

MEDICAL HISTORY **Patient Name**_____

- Primary Care Provider Name & Phone number:_____
- Date of last flu shot: _____; Date of last pneumonia Vaccine? _____
- Date of last Colonoscopy; _____ what is your BMI? _____
- Have you ever been screened for Clinical Depression? Yes □ No □ Date:_____
- Do you currently use any **tobacco** products? Yes □ No □ - If former smoker, how long ago did you stop?_____
  Type of tobacco product _____How much per day _____For how long_____
- **Alcohol** drinks per week_____

WOMEN: Are you **pregnant**? No □ Yes □ Month due? _____ Are you **nursing**? No □ Yes □
Are you on **birth control**? No □ Yes □ Type:___ Are you going or gone through menopause? No □ Yes □
Have you ever been screened for Osteoporosis? Date:_____ Urinary Incontinence? Date:_____
Date of last Mammogram:_____

PLEASE MARK PAST AND PRESENT CONDITIONS:

☐ Anxiety	☐ COPD	☐ Hearing Loss	☐ Mitral Valve Prolapse
☐ Arthritis	☐ Depression	☐ Heart Murmur	☐ Numbness or Tingling
☐ Atrial fibrillation	☐ Diabetes	☐ Hepatitis A, B, or C	☐ Pacemaker
☐ Artificial Heart Valve	☐ Drug or Alcohol Abuse	☐ HIV Positive or AIDS	☐ Radiation Therapy
☐ Artificial Joints	☐ Epilepsy or seizures	☐ High Blood Pressure	☐ Sinus Trouble
☐ Artificial Other_____	☐ Fainting or Dizzy Spells	☐ Low Blood Pressure	☐ Stroke
☐ Asthma		☐ Leukemia	☐ Thyroid Disease
☐ Bleeding Disorders	☐ Glaucoma	☐ Lymphoma	☐ Tuberculosis
☐ Chemotherapy	☐ Seasonal Allergies	☐ Kidney Disease	☐

Cancer or Cancer Treatment please describe:_____
Previous Surgeries – please describe:_____

RACE / ETHNICITY: Circle all that apply: Caucasian, Black/African American, Asian, American Indian, Native Hawaiian, Pacific Islander, Hispanic Latino, other_____

SKIN HISTORY (MARK ALL THAT APPLY)

☐ Acne	☐ Hay Fever	☐ Precancerous Moles	☐ Squamous Cell Carcinoma
☐ Psoriasis	☐ Melanoma	☐ Actinic Keratoses	
☐ Asthma	☐ Contact Dermatitis	☐ Skin Rash/Hives	☐ Other _____
☐ Dry Skin	☐ Flaking/itching scalp	☐ Basal Cell Carcinoma	
☐ Eczema	☐ Blistering Sunburns		

- Do you have a family history of **Melanoma**? Yes □ No □, if yes, relative(s)?_____
  Other family history of **skin cancer**? Yes □ No □, – if yes, please describe_____
  _____
- Do you wear **sunscreen**? Yes □ No □, *what SPF*?_____How often do go outdoors w/o sunscreen? _____
- Do you tan in a tanning salon? Yes □ No □, Have you in the past? Yes □ No □

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Erythromycin	☐ Local Anesthetics	☐ Penicillin	☐ Sulfa
☐ Latex		☐ Other _____	☐ Tetracycline

** Pharmacy - Name & number _____

Please list "ALL" Prescription and Herbal medications & Vitamins/Supplements that you are currently taking

_____
_____

- Do you take a **Daily Aspirin**? Yes □ No □ *Dose*_____ *Do you use* ***Anti-infammatories****?* Yes □ No □ *dose*_____

Patient Signature _____ **Date** _____
(Parent or guardian if patient is a minor)

CLINIC POLICIES
Advanced Dermatology & Laser Institute of Seattle

PAYMENT POLICY: Payment for services provided are due at the time of service, we accept all major credit cards as well as cash/checks. All Laser and cosmetic procedures require a 25% deposit to hold the time slot.

CANCELLATION POLICY: As a courtesy to our clinic, staff and other patients, we require 3 business days to change or cancel an appointment, in order to avoid a $75.00 cancellation fee. If the appointment was for a surgical or cosmetic procedure, the cancellation fee is 25% of the scheduled appointment. In the event ample notice is not given, the deposit will be applied to the cancellation fee.

LABORATORY / PATHOLOGY FEE AND RESULTS: As a part of your treatment, it may be necessary to have blood tests or a biopsy performed. All blood and biopsy specimens are sent to an outside laboratory for testing and analysis. You will be receiving a separate bill from the lab performing the tests, and their fees are in addition to those charged by Advanced Dermatology and Laser Institute of Seattle, Dr. Greene and staff.

INSURANCE POLICY: Your insurance policy is a contract between you and your insurance company. Insurance companies offer an array of choices for consumers & employees, and therefore it is your responsibility to understand the insurance package you have chosen, not all services are covered the same, even within an insurance company. You are responsible for all charges not paid by your selected carrier. As a courtesy to our patients we will submit your claim for you. At time of service, co-pays are required.

Timely Filing: It is your responsibility to inform us in a timely manner of any insurance changes. Please note, there are "timely filing of claims rules" insurance companies have the right to deny the claim completely if not received in a timely manner. We need correct insurance information within 60 days of your visit, otherwise you will be responsible for the payment of the service and we will print a claim for you to provide for your carrier.

Pre-Authorizations: Many insurance companies require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company BEFORE receiving medical services. If you have not received prior approval or the authorization has been denied, you are fully responsible for all charges that your insurance company does not agree to pay.

Insurance Preferred Providers: Advanced Dermatology and Laser Institute of Seattle has chosen to be network providers for some of the insurance carriers in the area, ask the front office for details of whom we are contracted with. Even though we are preferred providers, the policy you have chosen may not cover a Dermatology visit, it does not negate the co-pay @ the time of service and you still have a deductible to meet, as the field of Dermatology is not considered a preventative service.

Authorization for treatment, Release of information: I hereby authorize Advanced Dermatology and Laser Institute of Seattle to provide care and treatment and to release my medical information to my insurance company as necessary for payment of benefits. I authorize my insurance company to pay my benefits directly to Advanced Dermatology and Laser Institute of Seattle. This authorization remains valid and effective from the date of signing until revoked in writing.

REFUND POLICY: Patients are allowed 30 days after the date of purchase of any product, for a full refund, the unused portion must be returned. Services are not refundable, In the event that only part of a service package is used, the remaining services will not be refunded but rather transferred as different services.
For the treatment of minors, we hold parents or legal guardians responsible for any uncovered charges at time of service.

I have read and understand the above CLINIC POLICIES and all questions regarding this document have been answered.

****Patient Signature_____Date_____**

(Parent or guardian if patient is a minor)

RECEIPT OF PRIVACY: **I** have read the Notice of Privacy Practices that is presented to me in a separate document. Only if I request a written copy, will I receive a hard copy to take with me.

****Patient Signature_____Date_____**

(Parent or guardian if patient is a minor)

Patients Name_____ Date_____

GETTING TO KNOW YOU

Please describe your long term goals for the health of your skin_____

_____

What is your current skin care regimen?_____

- Do you have **fine lines** and **wrinkles**? Yes □ No □
- Are you experiencing **sagging** or **drooping** of the skin? Yes □ No □
- Do you have **sun spots** or **discoloration** on your face or body? Yes □ No □ Where_____
- Do you have any **stretch marks**? Yes □ No □, if yes - where_____
- Do you have any **scars or keloids** from past surgical procedures or trauma events? Yes □ No □, Please describe_____
- Are you experiencing **hair loss /thinning**? Yes □ No □
  - Want information on better hair products - Yes □ No □
  - Want information on great supplements - Yes □ No □
  - Want information on hair restoration - Yes □ No □
- Would you like longer, fuller, **Eyelashes** or eyebrows? Yes □ No □
  - Want information on Latisse - eyelash grow system - Yes □ No □

Is there anything you would like to change about your face or body?_____

_____

Check any of the following Laser Treatments you are interested in or would like more information about:

☐ Acne scaring	☐ Sun damage/age spots	☐ Youthful looking skin tone
☐ Fine Lines & Wrinkles	☐ Brown spots	☐ Skin Tightening
☐ Enlarged facial pores	☐ Skin Texture	☐ Skin rejuvenation

☐ **"Three for Me Laser Therapy" using the 1540 and Max G Laser – Targets: All the above issues; treatment consists of 3-4 visits set 1 month apart.**

☐ Rosacea	☐ Broken blood vessels	☐ Red spots
☐ Facial Veins	☐ Pigmentation	☐ Spider Veins legs
☐ Hair Removal	☐ Actinic Keratosis	☐ Stretch Marks
☐ Scars	☐ Nail Fungus	☐ Body Contouring
☐ Melasma	☐ Skin Tightening	

Check any of the following treatments or services you are interested in or would like more information about:

- ☐ Fillers
- ☐ Neuromodulators (eg. Botox)
- ☐ Medical Grade facials
- ☐ Chemical Peels – exfoliation & skin resurfacing
- ☐ Exilis Elite – skin tightening & fat reduction
- ☐ Kybella for removal of double chin
- ☐ Micro needling – reduce acnes scars & skin rejuvenation

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Why purchase skin care products from a Dermatologist Office?

Dr. Steven Greene, a Mayo Clinic trained, Board Certified Dermatologist, and Rene' Steele, our Master Aesthetician, both have extensive knowledge of skin and skin issues and have the experience to recommend safe and effective skin care products specifically for your skin type and/or condition. Every person's skin is different and therefore no two treatments are the same, in a dermatology clinic, products are specifically selected for you based on your individualized skin care needs after you receive a medical skin evaluation.
Dr. Greene has done extensive research on several medical grade skin care product lines. He has chosen the products we offer in our clinic for several reasons including scientific research, overall results, quality of ingredients and price point.

Why "medical grade" versus over the counter or Internet?

- **Medical grade:** Scientifically tested to be true of strength, safe shelf life and Paraben free. FDA approved products are allowed to contain higher concentrations and potency of active ingredients.
- **We specifically recommend products to our patients which:**
  - Best compliment the prescription medications you may be taking & are a safe combination.
  - Have been specifically selected to help you protect your investment following treatments.
  - Are best suited for your skin type, condition, lifestyle and needs.
  - Help to prolong the effects of treatments done here in our office.
- **Internet/TV/Over the Counter**: Unless a product is FDA approved, no matter how well the "Ad" is, they are not allow to be as strong as medical grade products or if it is beneficial for your skin or skin condition. There is also a growing concern of bait and switch of name brand products, even if the bottle says "Skin Medica" or "Lira" they may be expired products sold as fresh or even another product entirely. **That is not to say there are not reputable sites, we just want you to be aware and do your due diligence when shopping for products online.

Why stay on the recommended products?

Your skin, like the rest of your body, needs nourishment to maximize its best appearance. You have taken the time to receive a skin care recommendation from a Dermatologist and/or our Master Aesthetician. The best way to continue to see optimum results is to keep using the products as recommended. If at any time, you feel a product is not working or you would like a review of the products you currently are using please call our clinic.

How do I get more of the products sold in the office?

FREE Shipping! – on both auto ship and phone orders - we can ship products to you within a couple of days or feel free to stop by the office.

Can my family and friends purchase these products?

YES! We offer complimentary product consults. We strongly feel each patient's skin is unique and so we prefer to evaluate your family and friends first to make sure the best products are selected for their skin type, concern, and possible condition.

Return policy on products is 30 days for a full refund, we do not accept returns after that date.

206-402-4797 or Contactinfo@advanceddermatologyseattle.com to purchase more products