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	□ Other ___________
□ Asthma	□ Contact Dermatitis	□ Skin Rash/Hives	
□ 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
- ☐ Fine Lines & Wrinkles
- ☐ Enlarged facial pores
- ☐ Sun damage/age spots
- ☐ Brown spots
- ☐ Skin Texture
- ☐ Youthful looking skin tone
- ☐ Skin Tightening
- ☐ 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
- ☐ Facial Veins
- ☐ Hair Removal
- ☐ Scars
- ☐ Melasma
- ☐ Broken blood vessels
- ☐ Pigmentation
- ☐ Actinic Keratosis
- ☐ Nail Fungus
- ☐ Skin Tightening
- ☐ Red spots
- ☐ Spider Veins legs
- ☐ Stretch Marks
- ☐ Body Contouring

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