GROSSE POINTE DERMATOLOGY & COSMETIC CENTER

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(313) 886-2600

Name _____ DOB _____ Todays Date_____
Last First M.I.

Address_____City_____Zip Code_____

Home Phone #:_____ Cell Phone #: _____

May we leave a message if we receive your voicemail? YES or NO (if YES please indicate the number at which we may leave a message)

Sex: _____ Marital Status: S_____M_____W_____D_____

E-Mail: _____@_____.com

Emergency Contact Name: _____ Relationship: _____

Emergency Phone Number: _____

How did you hear about us? **Doctor Referral Family/Friend Web Search Social Media Magazine**

***Please give your insurance card to the front desk so we can make a copy for our files.**

Subscriber information (if different from patient) Name_____ DOB_____

Relationship to patient: _____

Responsible Party (if different from patient or patient is a minor)

Name: _____ Date of Birth: _____

Address (if different than patient):_____ Phone number: _____

Relationship to patient: _____

Primary Care Providers Name: _____ Phone #: _____

Location: _____ last visit to PCP: _____

Please fully complete all medical information

Please circle what applies to you-

Kidney disease/ Liver disease / Diabetes / High blood pressure / Cardiovascular disease/ Blood clotting disorders/ Organ transplant / Defibrillator/ Pacemaker/ HIV/ Blood thinners/ Artificial heart valve/ Artificial joints within the last 2 years/ Pre-medicates prior to procedures/ Pregnancy or planning/ Breastfeeding/ Allergy to Lidocaine/ Rapid heart rate with Epinephrine/ Problems with healingly complete all medical information/ Cancer/ Skin Cancer

Have you been vaccinated for pneumonia? Yes No

Have you been vaccinated for the flu this year? Yes No

Have you been vaccinated for COVID? Yes No **If yes, when was your last dose?** _____

How many times in the past year have you consumed 4 or more alcoholic beverages in one day? _____

Please indicate your smoking status: Never a smoker___ Former smoker___ Current smoker ___

Do you have any allergies? If *yes*, please list them:

_____

Are you on any medications? If *yes*, please list them or provide a list to copy:

_____

_____

HIPAA - I give you permission to discuss my protected health information with:

(Please list the name(s) of the person(s) you will allow our office to discuss your protected health information with. If no names are given and a person calls on your behalf without being listed on this form, we will **NOT** provide them with any information about yourself, including upcoming appointment times. Please add as many personal names as you need, you do not need to add physicians in this section.)

_____ _____

Name & Relationship **Name & Relationship**

I give Grosse Pointe Dermatology permission to speak to my pharmacy.

Pharmacy Name_____ **Phone number:** _____

Address: _____

_____ _____

Please sign this line **Date**

Patient Consent to Treatment & Financial Responsibility

I am at least 18 years of age or, if not, I am accompanied by a legal guardian, or have a signed letter from my legal guardian giving Grosse Pointe Dermatology permission to treat without my legal guardian present.

I hereby consent to and authorize an examination by my doctor and such assistant or staff as may be assigned by the physician. I authorize Grosse Pointe Dermatology to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare. Grosse Pointe Dermatology has contracts with many insurance companies to accept assignment of benefits for our services. In order to fulfill our contract with your insurance company we must obtain a copy of a valid insurance card and driver's license or other legal form of identification at the time of your visit or you will be charged as a private pay patient and charges for your visit will be your complete responsibility. You are responsible for knowing your insurance coverage and benefits. Insurance coverage varies from plan to plan.

Grosse Pointe Dermatology will not waive your financial responsibility if your insurance provider denies payment. Your copay and any past balance are expected at the time of service. We accept cash, check, credit card, and Care Credit.

As a service to you Grosse Pointe Dermatology will file your insurance claim. You will be billed for any amount not covered by your insurance company, including deductibles, surgical/pathology deductibles, co-insurance, non-covered services, unauthorized services, and services considered "medically unnecessary" by your insurance company. Payment is due upon receipt of your statement. It is the patient's responsibility to obtain and track any referrals/authorizations required by the patient's insurance company. If you do not have a referral that is required for coverage of your date of service we can still see you as a self-pay patient for that visit. Cosmetic services are not covered by health insurance, charges are payable on or before the day of service. Balances delinquent more than 120 days are subject to collection efforts and associated reporting to collection agencies.

I authorize that the payment of Medicare or other commercial insurance benefits be made to Grosse Pointe Dermatology for services provided.

I authorize the release of any information needed for processing of this or any related claim/s. I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

I understand that all outside laboratory testing will be billed from the specific laboratories to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment. A copy of the authorization shall be considered as valid as the original.

Photography is at times a necessary part of planning and evaluating treatment. Patient or responsible party authorize the taking of photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise agreed upon.

If it becomes necessary to cancel or change your appointment, we require at least 24 hours advanced notice. This is important so that we may offer this appointment time to another patient in need of seeing the doctor. If an appointment is canceled or changed with less than 24 hours' notice, there will be a $50 cancellation fee applied to your account for medical and Botox appointments, and a $100 cancellation fee for surgical or filler appointments. No- show appoints will result in a $50 fee for medical and Botox appointments, and a $100 fee for surgical and filler appointments. These fees will be the responsibility of the patient or party financially responsible for the patient.

I acknowledge I have read this information thoroughly and understand this patient financial responsibility form.

Print: _____

Signature: _____ Date: _____

Relationship to the patient (If other than patient) _____

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Skin Concern Self-Assessment

For many people, changes in physical appearance, especially as we age, can have a significant impact on self confidence and even quality of life. Fortunately, today there are many cosmetic products and procedures available to enhance and improve one's appearance. Please answer the following questions (circle answer):

When looking at my face in the mirror, I believe I look ___ than my true age. Younger Same Age Older

When looking at my face in the mirror, I am _____ about the appearance of lines and wrinkles on my face.
Not Concerned Somewhat Concerned Very Concerned

When looking in the mirror, I am _____ about the appearance of my body.
Not Concerned Somewhat Concerned Very Concerned

What cosmetic procedures, if any, have you had in the past?

_____

If you have previously had any cosmetic procedures, were you pleased with the outcome? Yes No N/A
If no, in what way were you dissatisfied?

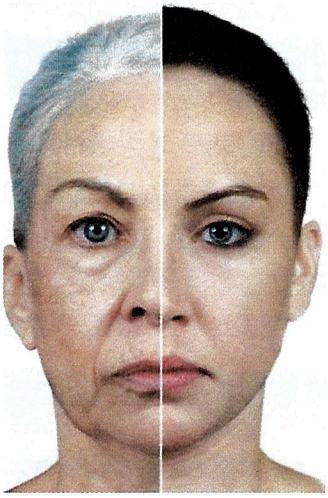
_____

What products are in your current skincare regimen (face/body)? (cleanser, treatments, moisturizer, sunscreen)

_____

Which of the following concerns would you like to address or learn more about? Check all that apply.

Forehead Lines
Frown Lines between Brows
Crows Feet
Dark Circles/Sunken Under Eyes
Loss of Facial Volume or Fullness
Sagging Earlobes
Lines around Nose and Mouth
Thin Lips
Chin/Jawline Definition
Sagging Skin
Neck Lines



Which of the following skin concerns would you like to address or learn more about? Check all that apply.

Acne
Hyperpigmentation/Brown Spots
Facial Redness or Spider Veins

Large Pores
Dry/Dull appearance
Rough Texture
Fine Lines and Wrinkles
Scarring

Thinning Hair
Sparse Eyelashes/Eyebrows
Excess Facial Hair

Over --->

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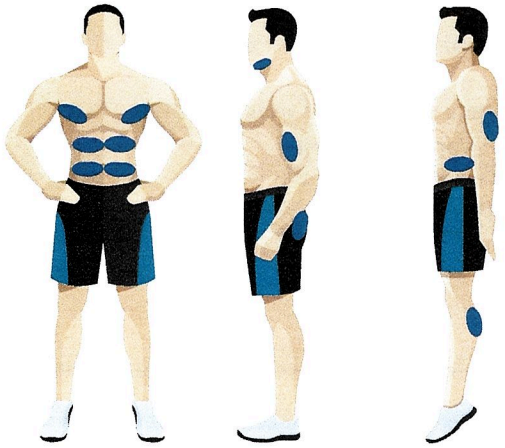
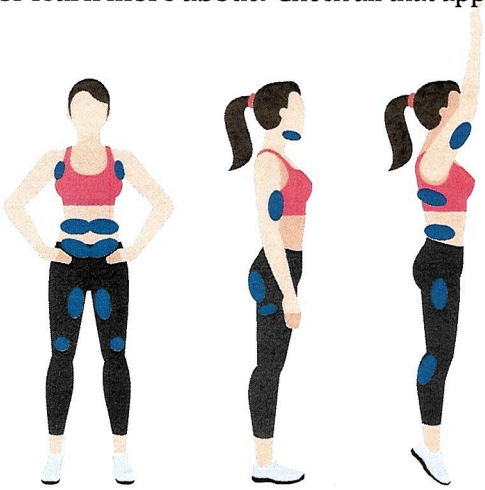
Skin Concern Self-Assessment

Which of the following body concerns would you like to address or learn more about? Check all that apply.



Double Chin
Chest
Upper Back
Upper Arms
Bra Line Bulges
Stomach
Flanks
Buttocks
Under Buttocks
Front/Back Thighs
Outer/Inner Thighs
Above the Knees
Calves



Crepey Skin
Aging Hands
Excessive Sweating

Excess Body Hair
Leg Veins

Stubborn Body Fat
Loss of Muscle Tone

How did you hear about us?

_____ Friend or Family Member (name)

_____ Physician Referral or Insurance Company (name)

_____ Advertisement (please specify)

_____ Internet (website)

Patient Information

_____
Name (please print) Phone number

We have special offers which are ONLY distributed via e-mail. Would you like to be contacted for exclusive promotions and events? __ Yes __ No

_____@_____.____
E-mail address (please print)