

WELCOME TO OUR OFFICE. PLEASE TAKE A MOMENT TO COMPLETE THIS FORM IN ITS ENTIRETY.

PERSONAL INFORMATION

LAST NAME	FIRST	INT	SS#	MARITAL STATUS S M D W	SEX M F	D.O.B.
STREET ADDRESS			CITY/ STATE/ ZIP		HOME PHONE	CELL PHONE
PATIENT'S OR PARENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE	
EMPLOYER'S ADDRESS			CITY/ STATE/ ZIP		DO YOU HAVE A PRIMARY CARE PHYSICIAN? Y N IF YES, WHO?	
SPOUSE'S EMPLOYER			OCCUPATION)		BUSINESS PHONE	
EMPLOYER'S ADDRESS			CITY/ STATE/ ZIP			
EMAIL ADDRESS:			REFERRED BY:			

INSURANCE INFORMATION

INSURED/PARTY RESPONSIBLE	ADDRESS (IF DIFFERENT FROM ABOVE)	Relationship to patient	Insured's DOB
			SS#
PRIMARY INSURANCE COMPANY	GROUP NUMBER	MEMBER ID NUMBER	
BILLING ADDRESS			
SECONDARY INSURANCE COMPANY	GROUP NUMBER	MEMBER ID NUMBER	
BILLING ADDRESS			

EMERGENCY CONTACTS

PLEASE LIST BELOW SOMEONE WE MAY CONTACT IN CASE OF AN EMERGENCY

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP
NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP

CURRENT PROBLEM

BRIEFLY STATE YOUR PROBLEM. DO YOU HAVE ANY SYMPTOMS LIKE BURNING OR ITCHING ASSOCIATED WITH IT?	
HOW LONG HAVE YOU HAD THIS?	HAVE YOU HAD IT BEFORE? IF SO, WHEN

ALLERGIES

PLEASE LIST **ANY AND ALL** MEDICATIONS THAT YOU HAVE HAD A REACTION TO AND WHAT TYPE OF REACTION YOU HAD.

PLEASE LIST ANY OTHER ALLERGIES YOU HAVE (i.e. HAY FEVER, ASTHMA, SINUS TROUBLE, POST NASAL DRIP, HIVES, EYE ALLERGY PLANTS, METALS, HAIR DYE OR OTHER:

MEDICAL HISTORY

LIST ANY MEDICAL CONDITIONS AND ONSET DATES

DIABETES Y N ONSET DATE _____
HIGH BLOOD PRESSURE Y N ONSET DATE _____
CANCER Y N ONSET DATE _____
ULCER Y N ONSET DATE _____
OTHER _____
ONSET DATE _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING DOSE AND FREQUENCY AS WELL AS VITAMIN SUPPLEMENTS AND ALTERNATIVE MEDICATIONS.

LIST ALL HOSPITALIZATION AND DATES

LIST ALL OPERATIONS AND DATES

SOCIAL HISTORY

ALCOHOL USE? Y N HOW LONG? _____
ARE YOU STILL USING? Y N
TABACCO USE? Y N HOW LONG? _____
ARE YOU STILL USING? Y N
ILLICIT DRUG USE? Y N HOW LONG? _____
ARE YOU STILL USING? Y N

FAMILY HISTORY (PLEASE INDICATE RELATIONSHIP TO YOU)

HEART DISEASE Y N
WHO? _____
HIGH BLOOD PRESSURE Y N
WHO? _____
CANCER Y N
WHO? _____
CONNECTIVE TISSUE DISEASE Y N
WHO? _____
DIABETES Y N
WHO? _____
OTHER _____
WHO? _____

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING:

APPETITE _____ MENSTRUATION _____
DIGESTION _____ TEETH _____
ELIMINATION _____ HAIR _____
URINATION _____ NAILS _____
SLEEP HABITS _____ MUSCLE SPASMS _____
ANXIETY _____ JOINT PAIN _____
VISION _____ OTHER _____

ARE YOU CURRENTLY PREGNANT? _____
IF YES, HOW LONG? _____
NUMBER OF PREGNANCIES _____ MISCARRIAGES _____
ARE YOU POST MENOPAUSAL? _____
IF YES, HOW LONG? _____

PATIENT SIGNATURE _____

DATE _____

PHYSICIAN SIGNATURE _____

DATE _____

PLEASE READ CAREFULLY

I UNDERSTAND THAT DR. ROSE DERMATOLOGY PARTICIPATES WITH CERTAIN INSURANCE CARRIERS. UNLESS A CONTRACTUAL ARRANGEMENT EXISTS BETWEEN DR. ROSE AND MY INSURANCE COMPANY, I AGREE TO PAY THE FEES IN FULL, EVEN THOUGH THE AMOUNT MAY BE GREATER THAN WHAT I AM ENTITLED TO RECEIVE FROM MY INSURANCE CARRIER. ANY CO/PAYS, DEDUCTIBLES, OR AMOUNTS DEEMED PAYABLE BY MY INSURANCE CARRIER SHALL BE MY RESPONSIBILITY. BALANCES REFLECTED ON THE OFFICE BILL, WHICH IS NOT EXPECTED TO BE REIMBURSED BY INSURANCE, SHALL BE PAYABLE BY ME. PROCEDURES DEEMED "COSMETIC", BY ANY INSURANCE CARRIER, WILL BE MY RESPONSIBILITY. THERE IS A \$25.00 FEE FOR ALL UNPAYABLE CHECKS.

SIGNATURE _____

DATE _____

AUTHORIZATION TO RELEASE/CONSENT

THIS WILL AUTHORIZE YOU TO RELEASE MEDICAL INFORMATION FOR THE PURPOSE OF MY CARE AND BILLING **ONLY** (I.E. ANOTHER PHYSICIAN, HEALTH INSURANCE CLAIMS) WITHOUT LIMITATION. MY CONSENT IS GIVEN FOR ELECTRONIC BILLING OF MY CLAIMS. THIS CONSENT IS VALID FOR THE DURATION OF MY TREATMENT UNLESS OTHERWISE NOTED BELOW.

SIGNATURE _____

DATE _____

CONSENT EXPIRATION DATE: _____

OUR LASER POLICY

IF YOU HAVE A LASER TREATMENT, PLEASE BE ADVISED THAT THERE WILL BE A CHARGE FOR **EACH** LASER TREATMENT THAT YOU RECEIVE INCLUDING TOUCH UPS. WE TRY TO BE VERY FAIR WITH OUR PRICES. DUE TO THE COST OF THE LASERS, IT IS IMPOSSIBLE TO PROVIDE "FREE" LASER TREATMENTS.

SIGNATURE ACKNOWLEDGING LASER POLICY

**DIANE LORIA ROSE, M.D. F.A.A.D
ROSE DERMATOLOGY & LASER, LLC
AMERICAN BOARD OF DERMATOLOGY
CERTIFIED**

AN IMPORTANT MESSAGE REGARDING MOLES AND MELANOMAS

THE INCIDENCE OF MALIGNANT MELANOMA IS ON THE RISE. IN EFFORT TO IDENTIFY AND TREAT THIS CONDITION, IT IS RECOMMENDED THAT A TOTAL SKIN OR DERMATOLOGICAL BODY EXAM BE PERFORMED. BY VISUAL EXAMINATION OF MOLES, ON THE SKIN, WE CAN EVALUATE THE STATUS OF THOSE LESIONS AND DETERMINE IF TREATMENT IS NEEDED AT THIS TIME,

NO ONE KNOWS WHAT THE STIMULUS IS FOR SUCH LESIONS TO UNDERGO MALIGNANT CHANGES. VARIOUS FACTORS SUCH AS SPORADIC SUN BURNS, PROLONGED SUN EXPOSURE, TRAUMA, FRICTION, HORMONAL INFLUENCES AND HEREDITY HAVE BEEN INVOLVED IN THE DEVELOPMENT OF MALIGNANT CHANGES (CALLED MELANOMA). BECAUSE OF THE RAPID EVOLUTION OF MELANOMAS, IT IS OF THE UTMOST IMPORTANCE THAT QUICK AND EARLY DIAGNOSIS BE MADE. TREATMENT MUST BE DONE TO REMOVE SUCH A LESION ENTIRELY AND THOROUGHLY. CURRENTLY, PROGRESS IS BEING MADE IN THE CHEMICAL TREATMENT OF THOSE PATIENTS WHOSE DISEASE HAS SPREAD TO OTHER PARTS OF THE BODY; HOWEVER THE BEST HOPE IS FOR EARLY DIAGNOSIS AND REMOVAL.

DERMATOLOGISTS ARE TRAINED TO CLINICALLY RECOGNIZE THE TYPES OF CHANGES THAT TAKE PLACE IN MELANOMA AND ARE KNOWLEDGEABLE OF THE MICROSCOPIC ASPECTS OF THIS CONDITION. APPROACHES IN TREATMENT OF SUCH LESIONS ARE IN THE FOREFRONT OF GOOD DERMATOLOGICAL PRACTICE. ANY CHANGE WHATSOEVER IN A MOLE SHOULD BE CAREFULLY EVALUATED BY A DERMATOLOGIST.

ACCORDINGLY, THIS DERMATOLOGICAL PRACTICE IS OFFERING TO PATIENTS TOTAL BODY DERMATOLOGICAL EXAMINATION WITH APPROPRIATE RECOMMENDATIONS. THIS WILL INCLUDE A FULL HEAD-TO-TOE SURVEY OF THE ENTIRE SKIN. ANY SUSPICIOUS LESIONS CAN AND WILL BE REMOVED. THAT TISSUE WILL BE SENT FOR HISTOLOGICAL EXAMINATION BY A BOARD CERTIFIED DERMOPATHOLOGIST WHO WILL BILL YOU DIRECTLY. THE USUAL SURGICAL FEES WILL BE APPLIED FOR SUCH SERVICES IN THIS OFFICE.

ON THIS VISIT TO OUR OFFICE TODAY WE EXTEND TO YOU THE OPPORTUNITY TO HAVE THE ABOVE NOTED DERMATOLOGICAL EXAMINATION PERFORMED ON YOU. BECAUSE OF THE IMPORTANCE OF THIS VERY SERIOUS CONDITION, WE RECOMMEND THAT IT BE DONE.

PLEASE SIGN AND DATE THIS FORM ACKNOWLEDGING WHETHER OR NOT YOU WISH TO HAVE THIS PROCEDURE PERFORMED.

_____ YES, I WISH TO HAVE THE EXAMINATION PERFORMED.

_____ NO, I DO NOT WISH TO HAVE THE EXAMINATION PERFORMED.

SIGNATURE

DATE