PATIENT INFORMATION (PLEASE PRINT) TODAY'S DATE ____/____/____

NAME_____
LAST FIRST M.I.

ADDRESS_____
CITY /STATE ZIP

Please check the box of the primary phone number where you would prefer we reach you.

☐ HOME PHONE_____ ☐ WORK PHONE_____ ☐ *CELL PHONE_____
Area Code Area Code Area Code

EMPLOYER _____ OCCUPATION: _____

DATE OF BIRTH_____/_____/_____ SEX _____ MARITAL STATUS: S_____ M ____ W ___ D ____

***Emergency Contact Name: _____**

***Phone Number: _____ *Relationship:_____**

RESPONSIBLE PARTY (IF DIFFERENT FROM PT)

NAME_____
LAST FIRST M.I.

ADDRESS_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE _____
Area Code Area Code Area Code

DATE OF BIRTH_____/_____/_____ SEX _____ MARITAL STATUS: S_____ M ____ W ___ D ____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK-IN)

PRIMARY INSURANCE NAME _____

NAME OF INSURED _____ Date of Birth _____

INSURED'S ID # _____

GROUP # _____

RELATIONSHIP OF PT TO INSURED _____

EMPLOYER NAME _____

EMPLOYER PHONE _____
AREA CODE

SECONDARY INSURANCE NAME _____

NAME OF INSURED _____

INSURED'S ID # _____

GROUP # _____

RELATIONSHIP OF PT TO INSUREDD _____

EMPLOYER NAME _____

EMPLOYER PHONE _____
AREA CODE

REFERRED BY: _____

PATIENT QUESTIONNAIRE

Name: _____

1. **ARE YOU ALLERGIC TO ANY MEDICATION (S)? _____ YES _____ NO**
   If yes, please list which one (s).
2. **WHAT IS THE REASON FOR YOUR VISIT TODAY?**
3. **WHERE IS YOUR SKIN PROBLEM LOCATED?**
4. **HOW LONG HAVE YOU HAD THIS CONDITION? (How many days, weeks, months, years?)**
5. **HAVE YOU EVER BEEN TREATED BY ANOTHER PHYSICIAN FOR TODAY'S PROBLEM? IF SO, PLEASE LIST THE PHYSICIAN'S NAME & TREATMENT.**
6. **HAVE YOU EVER TAKEN ANY OTHER MEDICATIONS (S) FOR TODAY'S PROBLEM? IF SO, PLEASE LIST.**
7. **IN YOUR OPINION, HOW IS YOUR GENERAL HEALTH? (excellent, good, fair, poor).**
8. **ARE YOU CURRENTLY ENROLLED IN ANY HOSPICE PROGRAM? _____YES Date Enrolled:_____**
   _____ NO
9. **PLEASE LIST ANY OTHER PHYSICIAN'S THAT YOU SEE AND THE CONDITIONS THAT THEY TREAT.**
10. **HAVE YOU EVER HAD SKIN CANCER? _____ YES _____ NO**
11. **HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD SKIN CANCER? _____ YES ____ NO**
12. **DO YOU SMOKE? _____ YES _____ NO**
13. **PLEASE WRITE DOWN THE NAMES OF ALL MEDICATION (S) YOU ARE NOW TAKING, INCLUDING BIRTH CONTROL PILLS OR ERECTILE DYSFUNCTION MEDICATIONS (E.D.).**
14. **HAVE YOU TAKEN ASPIRIN OR OTHER PAIN RELIEVERS IN THE PAST MONTH?**
    _____ YES _____ NO (IF YES, PLEASE LIST THEM AND HOW OFTEN)
15. **DO YOU TAKE ANY BLOOD THINNERS? _____ YES _____ NO**
    (IF YES, PLEASE LIST WHICH ONE (S)
16. **DO YOU HAVE A PACEMAKER OR IMPLANTED DEFIBRILLATOR? _____ YES ____ NO**
17. **ARE YOU REQUIRED TO TAKE ORAL ANTIBIOTICS PRIOR TO DENTAL WORK?**
    _____ YES _____NO

FEMALES ANSWER ONLY:

1. **WHEN WAS YOUR LAST MENSTRUAL PERIOD?**
2. **IS THERE ANY POSSIBILITY THAT YOU MAY BE PREGNANT? ____YES ____ NO**
3. **ARE YOU CURRENTLY BREASTFEEDING? _____YES _____ NO**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR GROSSE POINTE DERMATOLOGY ASSOCIATES, P.C.

With my consent**, Grosse Pointe Dermatology Associates, P.C.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Please refer to **Grosse Pointe Dermatology Associates, P.C..'s** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Grosse Pointe Dermatology Associates, P.C**. reserves the right to revises its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Grosse Pointe Dermatology Associates, P.C. Privacy Officer at 18050 Mack Avenue, Grosse Pointe, MI 48230.**

With my consent**, Grosse Pointe Dermatology Associates, P.C**. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Grosse Pointe Dermatology Associates, P.C**. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Grosse Pointe Dermatology Associates, P.C**. staff may also speak with the following members of my family about my TPO:

_____ Father _____ Son/Daughter **Name**: _____
Phone Number: _____

_____ Mother _____ **None – myself only**

_____ Spouse _____ Other **Name**: _____
Phone Number: _____

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Grosse Pointe Dermatology Associates, P.C.'s** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Grosse Pointe Dermatology Associates, P.C**. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Dear Patient:

We ask that you please read and sign this because it concerns all of us. Due to the many changes in insurance policies it is no longer an easy task to interpret each individual policy. Although we try to stay aware of changes, insurance companies often notify us of these changes after they have taken effect. Therefore, we urge you, as the patient, to please check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in your being responsible for the costs incurred. You must know if your employer or insurance company has contracted with a specific facility for lab, x-ray, and other special procedure services. If the service is performed by the wrong facility, you are potentially responsible for the bill.

In addition, if you are a member of a Health Maintenance Organization (HMO), Point of Service (POS), or other Managed Care insurance plans, there are specific rules that you must follow in order for them to pay for your care.

> Your insurance will not pay if you go to any specialist or testing facility unless your primary care physician sees you first and formally refers you to a specialist in the insurance network system. Most insurance companies will not approve referrals retroactively, so be sure that your visit or procedure has been pre-authorized by your insurance company prior to your visit to our office.

Please learn about your coverage. It could save you time and money in the long run.

Thank you,

Judith Lipinski, M.D.
David Balle, M.D.

I have read and understand these basic insurance policies and will notify the practice of any changes in my insurance benefits.

Signature of patient or guardian **date**

Assignment of Insurance Benefits

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I authorize release of all medical information required to process my claims and is pertinent to my medical care. My signature on this document authorizes direct payment to the physicians. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I understand that I am financially responsible for charges not covered by this assignment.

Signature of patient or guardian **date**

Skin Concern Self-Assessment

Our practice is constantly striving to offer you the safest, most advanced procedures for skin rejuvenation and overall physical improvement. Which of the following health concerns would you like to address and/or learn more about? (Please check all that apply.)

- ☐ Frown lines between the brows
- ☐ Crows feet and forehead lines
- ☐ Significant lines around nose and mouth
- ☐ Fine lines and wrinkles
- ☐ Overall skin rejuvenation
- ☐ Hyperpigmentation
- ☐ Acne
- ☐ Large pore size
- ☐ Dry skin
- ☐ Rough skin texture
- ☐ Sun damage
- ☐ Facial redness or dilated blood vessels
- ☐ Dark circles under eyes/tear troughs
- ☐ Thin lips
- ☐ Sagging skin
- ☐ Restoring facial volume or fullness
- ☐ Loose and/or sagging earlobes
- ☐ Hand rejuvenation
- ☐ Excess facial and/or body hair
- ☐ Bluish or purple leg veins
- ☐ Excess body fat in the neck, abdomen, hips, flanks, back, arms, and/or thighs
- ☐ Excessive underarm perspiration
- ☐ Thin, sparse eyelashes
- ☐ Other, please specify: _____

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

_____

Please answer the following questions (circle answer):

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

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 not **_____** about the appearance of my body.
Not Concerned **Somewhat Concerned** **Very Concerned**

How did you hear about us?

_____ _____
Friend or family member (name) Physician Referral or Insurance Company (name)

_____ _____
Advertisement (please specify) Internet (website)

Patient Information

_____
Your name (please print) Address Phone number

We frequently have special offers which are **ONLY** distributed via e-mail. Would you like to be contacted for exclusive events and promotions?

___ Yes ___ No _____@_____._____
E-mail address (please print)