Bellevue Acne Clinic

Name _____

Date of Birth _____ Age _____

Phone _____ □ Cell □ Home □ Other Gender: _____

Email Address _____

Address _____

City _____ State _____ Zip_____

Marital Status _____

Preferred method of communication: □ Phone □ Email □ Text

Emergency contact _____ Emergency Contact Phone _____

Employment: □ Full-Time □ Part-Time □ Unemployed □ Full-Time Student □ Part-Time Student

Current occupation or school_____

How did you hear about us? _____

Family Doctor's Name _____

Family Doctor's Clinic and/or Phone _____

Do you have health insurance? □ Yes □ No Insurance Company: _____

Is the insurance through you, or a family member? □ Self □ Spouse □ Parent □ Domestic Partner

Policyholder's Name _____

Policyholder's DOB: _____

Any secondary insurance? _____

Notes on Privacy

- Photographs are taken at every visit. They are kept confidential and are part of the medical record. They are not released without your permission.

- We will never ask for protected health information (PHI) via e-mail. However, we may communicate with you by e-mail to discuss non-PHI. If you choose to e-mail us with PHI, please know that our e-mail system is not encrypted and is therefore not secure.

Financial Policy:

- Full payment is due at the time of your visit if we are not billing your insurance. We require that you provide our office with your insurance card, unless your total charge is paid by cash or credit card at the time of service. If paying by check, we require a copy of your drivers' license.

- All co-pays and deductibles are due at the time of service. We will also collect all previous outstanding patient balances at the time of your visit. If you are a self-pay patient, payment is due at the time of service unless prior arrangements have been made. We accept cash, check, Visa and MasterCard and Discover.

- As a service to you, we will file your insurance claim if you provide us with the correct information and assign the benefits to the provider.

- There is a $25.00 fee assessed for all checks returned unpaid by banks.

- The financial responsibility of minor patients belongs to the accompanying parent or guardian.

Cancellation Policy

- Cancellations must be made by phone or email 24 hours before the scheduled appointment time, or the patient shall be responsible for the cost of the entire visit.

Release of information

- You must complete an "Authorization for Release of Medical Information" form prior to your records being released. There is no fee for records to be released to health care providers and health insurance providers with which we contract. There is a fee to release your medical record to an individual, including yourself. There is a fee to release your medical record to an insurance company with which we do not contract. There is an additional fee for the release of photographs taken by Bellevue Acne Clinic.

- If you present an insurance card at the time of your visit, and you request us to bill your insurance company, you authorize us to release all medical information which is requested by your insurance company.

Emergencies

- If you require medical care when the office is closed, please go to your nearest Emergency Department or call 911. Due to the nature of the service we offer, 24-hour availability of the provider is generally not available.

I agree to the above policies. I have received a copy of our "Patient Notice of Privacy Practices." If the patient is a minor, I am the parent or legal guardian of the above named individual, and I authorize Bellevue Acne Clinic to provide medical care to the above named individual.

Signature of Patient/Guardian_____ Date _____

Bellevue Acne Clinic

Medical History

Drug Allergies _____ Other Allergies _____

Main concern today: ☐ Acne on Face ☐ Acne on Body ☐ Acne Scarring ☐ Rosacea ☐ Other: _____

Describe any hospitalizations or surgeries. What year?

_____ _____

_____ _____

What medications or vitamin supplements do you take?

_____

_____

_____

_____

What medical conditions do you currently have?

_____

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate

# of alcohol drinks per week _____

Use of tobacco: ☐ Never ☐ Rarely ☐ Daily

What products do you use on your face?

_____

_____

_____

_____

_____

Women only:

Last menstrual period? _____

Would you describe your periods as

Irregular? ☐ Heavy Flow? ☐

Especially Painful? ☐ Light Flow? ☐

Describe other problems with your period:

_____

_____

Women only:

Date of most recent PAP _____

Most recent PAP: ☐ Normal ☐ Abnormal

What method do you use to prevent pregnancy?

_____ ☐ Not applicable

Any chance you might be pregnant? Yes ☐ No ☐

Do you have hair growth on your face? Yes ☐ No ☐

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