Shondra L. Smith, M.D.
DERMATOLOGY & ADVANCED AESTHETICS

New Patient Intake Forms

Patient Demographics
Full Name:_____

Date of Birth: _____ Birth Sex: [ ] Male [ ] Female

Preferred Language: _____ Marital Status: _____

Cell Phone Number: _____ Home: _____

Email Address: _____

Preferred Contact Method: [ ] Phone [ ] Email [ ] Patient Portal

Mailing Address:_____
_____
_____

Primary care physician: _____

Guarantor Information (If Patient is a Minor)
Guarantor Name:_____
Relationship to Patient: _____Phone Number:_____
Guarantor Address (if different):
_____
_____
_____

Insurance Policy Holder Information
Policy Holder's Name:_____
Policy Holder's Date of Birth: _____ Relationship to Patient: _____

Preferred Pharmacy
Pharmacy Name: _____

Address: _____ Phone: _____

Name:_____
DOB:_____

Allergies and Medications
Do you have any drug allergies?

[ ] Yes [ ] No
If yes, please list below:

_____
_____
_____
_____
_____

Current Medications (include dosage/frequency):

list attached: [ ] Yes [ ] No

_____
_____
_____
_____
_____
_____

Smoking Habits
[ ] Never Smoker [ ] Current Every day Smoker [ ] Smoke occasionally [ ] Former Smoker

Major Illnesses or Surgeries
Please list:

_____
_____
_____
_____
_____

Family History of Melanoma
Do you have a family history of melanoma? [ ] Yes [ ] No
Check all that apply: [ ] Mother [ ] Father [ ] Sister [ ] Brother [ ] Daughter [ ] Son
[ ] Aunt [ ] Uncle [ ] Grandmother [ ] Grandfather [ ] Niece [ ] Nephew
[ ] Grandson [ ] Granddaughter [ ] None Other: _____

Skin Conditions
[ ] Acne
[ ] Actinic keratosis
[ ] Asteatosis cutis
[ ] Basal cell carcinoma
[ ] Contact dermatitis
[ ] Dysplastic nevus
[ ] Eczema
[ ] Asthma (history of)
[ ] Hay fever
[ ] Malignant melanoma
[ ] Pruritus of scalp
[ ] Psoriasis
[ ] Squamous cell carcinoma
[ ] Second-degree sunburn
[ ] Other_____
[ ] None

Skin Protection
Do you wear sunscreen? [ ] Yes [ ] No If yes, what SPF? _____

Do you tan in a tanning salon? [ ] Yes [ ] No

Name:_____
DOB_____

Review of Systems: Please indicate any personal history of currently active problems.

Unintentional weight loss	[ ] Yes	[ ] No	Problems with scarring (hypertrophic or keloid)	[ ] Yes	[ ] No
Fever or chills	[ ] Yes	[ ] No	History of Radiation	[ ] Yes	[ ] No
Night sweats	[ ] Yes	[ ] No	Varicose veins	[ ] Yes	[ ] No
Fatigue	[ ] Yes	[ ] No	Breast pain	[ ] Yes	[ ] No
Eye disease or eye injury	[ ] Yes	[ ] No	Breast lump	[ ] Yes	[ ] No
Cataracts/glaucoma	[ ] Yes	[ ] No	Breast discharge	[ ] Yes	[ ] No
Problems with hearing	[ ] Yes	[ ] No	Frequent headaches	[ ] Yes	[ ] No
Sore throat	[ ] Yes	[ ] No	Light headed	[ ] Yes	[ ] No
Voice change	[ ] Yes	[ ] No	Convulsions/seizures	[ ] Yes	[ ] No
Swollen glands	[ ] Yes	[ ] No	Stroke	[ ] Yes	[ ] No
Nose bleeds	[ ] Yes	[ ] No	Nervousness/anxiety	[ ] Yes	[ ] No
Mouth sores	[ ] Yes	[ ] No	Depression	[ ] Yes	[ ] No
Chest pain	[ ] Yes	[ ] No	Glandular or hormone problem	[ ] Yes	[ ] No
Palpitations	[ ] Yes	[ ] No	Thyroid problems	[ ] Yes	[ ] No
Shortness of breath	[ ] Yes	[ ] No	Diabetic (insulin or noninsulin)	[ ] Yes	[ ] No
Swelling feet/ankles	[ ] Yes	[ ] No	Problems with healing	[ ] Yes	[ ] No
High blood pressure	[ ] Yes	[ ] No	Problems with bleeding	[ ] Yes	[ ] No
Lung disease	[ ] Yes	[ ] No	Anemia	[ ] Yes	[ ] No
Difficulty breathing	[ ] Yes	[ ] No	Phlebitis	[ ] Yes	[ ] No
Asthma/wheezing	[ ] Yes	[ ] No	Past transfusions	[ ] Yes	[ ] No
Intestinal/stomach disease	[ ] Yes	[ ] No	Blood or Lymph gland disorders	[ ] Yes	[ ] No
Liver or gallbladder disease	[ ] Yes	[ ] No	Cancer or leukemia	[ ] Yes	[ ] No
Abdominal pain	[ ] Yes	[ ] No	History of venereal disease (STD)	[ ] Yes	[ ] No
Peptic ulcers	[ ] Yes	[ ] No	History of HIV infection/AIDS	[ ] Yes	[ ] No
Bladder problems	[ ] Yes	[ ] No	Hepatitis	[ ] Yes	[ ] No
Kidney disease	[ ] Yes	[ ] No	History of frequent infections	[ ] Yes	[ ] No
Problems with urination	[ ] Yes	[ ] No	If yes, where? _____		
Kidney stones	[ ] Yes	[ ] No	History of reaction to:		
Sexual difficulty	[ ] Yes	[ ] No	Local anesthesia:	[ ] Yes	[ ] No
Testicle pain/lumps	[ ] Yes	[ ] No	Latex/rubber:	[ ] Yes	[ ] No
Prostate problems	[ ] Yes	[ ] No	Pacemaker	[ ] Yes	[ ] No
Irregular periods	[ ] Yes	[ ] No	Defibrillator	[ ] Yes	[ ] No
Estrogen replacement	[ ] Yes	[ ] No	Artificial heart valve	[ ] Yes	[ ] No
Hysterectomy	[ ] Yes	[ ] No	Pregnancy or planning pregnancy	[ ] Yes	[ ] No
Breast feeding	[ ] Yes	[ ] No	Blood thinners	[ ] Yes	[ ] No
Joint aches	[ ] Yes	[ ] No	Allergy to adhesive	[ ] Yes	[ ] No
Muscle weakness	[ ] Yes	[ ] No	West Africa: travel or contact	[ ] Yes	[ ] No
Artificial joints	[ ] Yes	[ ] No	Food Allergies: _____		

Practice Acknowledgements

Dermatology and Advanced Aesthetics
3635 Nelson Rd
Lake Charles, LA 70605
(337) 477-0011

Patient name: _____

Date of Birth: _____

HIPAA ACKNOWLEDGEMENT

You can find our Notice of Privacy Practices on our website under the "Contact Us" tab, or we can give you a physical copy at our front desk. You may keep that copy for your records.

I have received the Notice of Privacy Practices and I have been provided with the opportunity to review it.

Signature: _____ Date: _____

NOTICE OF FINANCIAL RESPONSIBILITY

I understand it is my responsibility to contact my insurance company to establish if Dermatology and Advanced Aesthetics is an approved facility for dermatology services and obtain any referrals that my insurance company requires **PRIOR** to my appointment. Dermatology and Advanced Aesthetics will file my claim as a courtesy. I understand that if for **any** reason my claim is denied, **I will be responsible for any and all non-covered services.** I also understand that balances over 90 days past due, with no attempt to pay, will be turned over to a collection agency.

_____

Printed name of person with financial responsibility

_____ Date: _____

Signed name of person with financial responsibility

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DERMATOLOGY & ADVANCED AESTHETICS

No-Show and Late Policy Acknowledgement

In order to provide the best care to all of our patients, Dermatology & Advanced Aesthetics has the following no-show and late policy in place:

- Patients who arrive more than **__**10 minutes late**__** for their scheduled appointment may be asked to reschedule. We will do our best to accommodate you, but we cannot guarantee you will be seen.

- **New patients** are required to arrive **__**30 minutes early**__** to their appointment with completed new patient forms, a valid photo ID, and insurance cards. Failure to bring insurance cards at the time of visit will result in the patient being treated as **__**self-pay**__**, and full payment will be due at the time of service.

- If you must cancel or reschedule your appointment, a **__24-hour notice__** is required. Cancellations or missed appointments without notice will result in a **__$30 fee__**.

- Our credit card machine applies a $2 transaction fee for all card payments except Health Savings Account (HSA) cards. To avoid this fee, patients may choose to pay with cash or check.

We appreciate your understanding and cooperation in helping us maintain an efficient and effective schedule for all patients.

I have read and understand the no-show and late policy outlined above.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Authorization for Release of Protected Health Information (PHI)

I authorize Dermatology & Advanced Aesthetics to disclose my protected health information (PHI) to the individuals listed below. This may include, but is not limited to, appointment information, test results, treatment plans, and billing information.

This authorization remains in effect until revoked in writing by the patient or legal guardian.

I understand that:
- I may revoke this authorization at any time in writing.
- Revocation will not affect information already disclosed.
- Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected.
- I may refuse to add anyone this authorization, which will not affect my ability to obtain treatment.

Please list individuals with whom we may discuss your PHI:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Patient Name (Printed): _____ Date of birth: _____

Patient Signature: _____

Date: _____

If patient is a minor or unable to sign:

Name of Legal Guardian or Representative: _____

Relationship to Patient: _____

Signature of Legal Guardian or Representative: _____

Date: _____

Dermatology and Advanced Aesthetics

Consent for Minor Dermatologic Procedures

Patient Name: _____

Date of Birth: _____

This form authorizes the providers at Dermatology and Advanced Aesthetics to perform minor dermatologic procedures as medically indicated. These may include, but are not limited to:

· - Skin biopsy (shave, punch, or excisional)
· - Destruction of benign or precancerous lesions using liquid nitrogen or other modalities
· - Local anesthetic or steroid (Kenalog) injections
· - Intralesional injections or aspiration of cysts
· - Curettage of lesions
· - Incision and drainage of cysts or abscesses
· - Irrigation and debridement of wounds or lesions
· - Other minor dermatologic treatments as discussed with the provider

Risks and Possible Complications

I understand that while these procedures are typically low risk, there are potential complications, which may include:

· - Pain or discomfort during and after the procedure
· - Bleeding, bruising, swelling, or infection
· - Scarring, discoloration, or delayed healing
· - Allergic reactions to medications or materials used
· - Need for additional procedures or treatments

Consent and Acknowledgment

I understand that the purpose of these procedures will be explained to me, including any potential risks, benefits, and alternatives. I understand that no guarantees have been made regarding the outcome. I understand I will have the opportunity to ask questions, and have the right to decline any procedure.

I understand that this consent will remain in effect for all minor procedures performed as part of my ongoing care, unless revoked in writing.

Signature of Patient (or Guardian if minor): _____

Date: _____

Printed Name of Guardian (if applicable): _____

Relationship to Patient: _____

Consent for Photo Documentation

As part of my medical care at Dermatology & Advanced Aesthetics, I understand that clinical photographs may be taken of me. These photographs may be used for the following purposes:

- Monitoring changes in skin lesions over time
- Documentation before and after procedures or biopsies
- Inclusion in my confidential medical record for diagnostic and treatment planning purposes

I understand that these photographs are a standard part of dermatologic documentation and will be kept strictly confidential. They will not be used for any publication, marketing, or educational purposes outside of my direct medical care without my additional written consent.

I understand that I have the right to refuse photography, and my decision will not affect the care I receive.

I consent to the use of medical photography as described above.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

If patient is a minor or unable to sign:

Name of Legal Guardian or Representative: _____

Relationship to Patient: _____

Signature of Legal Guardian or Representative: _____

Date: _____