YAG-HOWARD
COSMETIC DERMATOLOGY

PATIENT INFORMATION

Name: ____ Date of Birth: ________________

Email: ____________________________________ Social Security #: _________________________

Cell Phone: _________________________________ Home/Work Phone: ______________________

Preferred Contact Number & Method: _________________________ ☐ Text ☐ Email ☐ Cell ☐ Home

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

LOCAL ADDRESS: ____

OTHER ADDRESS: ____

Referred By: ☐ Friend ☐ Family ☐ Website/Internet ☐ TV ☐ Radio ☐ Print Ad ☐ Doctor: ________________

Primary Care Doctor Name & Phone: ____

Pharmacy Name & Number: ____

Emergency Contact Name & Number: ____

FINANCIAL POLICY for Cosmetic & Medical Patients:

- Payment for services is due in full at the time service is provided. We respectfully request 24-hr advance notice if you need to cancel or reschedule to avoid a cancellation fee.
- We accept: American Express, MasterCard, Visa and CareCredit (6 months, zero interest), Cash & Checks.
- Cosmetic Consultations are complimentary (filler, neurotoxins, lasers, skin tightening, skincare, etc.).
- ***Medical evaluations and care is not complimentary*** (moles, hairloss, acne, rashes, skin exams, melasma, biopsies, excisions, freezing, skin tags, etc.). Some medical conditions benefit from a cosmetic treatment plan, but evaluation and potential treatment (i.e., prescriptions, labs, biopsies, etc.) of medical issues is charged at 15% above the current Approved Medicare Allowed Amount. Payment is due from you at time of service for all but our Medicare patients. Whenever possible we will file a courtesy claim with your insurance on your behalf. ***Please ask us if you are unsure if your condition may be medical and require payment. We are happy to provide a cost estimate and want you to be fully informed and engaged in your care plan.***

SHARING YOUR INFORMATION:

YES	NO	In the interest of ensuring comprehensive medical care, I give Advanced Dermatology and Skin Surgery Specialists PA (dba Yag-Howard Dermatology and Aesthetic Center) permission to:
		Leave a voicemail or text message at my Preferred Contact # concerning biopsy results, lab tests, or any other protected health information (PHI).
		** Share my PHI with other health care providers, laboratories, pathology offices and related medical service providers as necessary.
		** Share my PHI with insurance companies.
Discuss my biopsy results, lab tests, or any other PHI with the following people: (NAME / RELATIONSHIP):		

** IF YOU DECIDE TO CHECK "NO" TO SHARING YOUR PHI WITH INSURANCE COMPANIES, OTHER HEALTH CARE PROVIDERS, LABORATORIES, PATHOLOGY OFFICES, AND OTHER RELATED MEDICAL SERVICE PROVIDERS (AS NECESSARY), WE WILL NOT BE ABLE TO SUBMIT A COURTESY CLAIM OR TAKE ANY BIOPSIES FOR YOU.

INTIALS __________

Past Medical Conditions – please ✓ all that apply.

	Anxiety Disorder		Diabetes Mellitus		Hypercholesterolemia		Radiation Therapy Treatment Management
	Arthritis		Disease caused by 2019-nCoV		Hyperthyroidism		Transplantation of Bone Marrow
	Asthma		Elevated Blood Pressure		Inflammatory Disease of Liver		H/O: Non-Skin Related Cancer (Please List Below)
	Atrial Fibrillation		End-Stage Renal Disease		Leukemia		-
	Benign Prostatic Hyperplasia		Epilepsy		Malignant Lymphoma		-
	Cerebrovascular Accident		Gastroesophageal Reflux Disease		Malignant Tumor of Breast		-
	Chronic Obstructive Lung Disease		H/O: hypertension		Malignant Tumor of Colon		-
	Coronary Arteriosclerosis		Hearing Loss		Malignant Tumor of Lung		-
	Depressive Disorder		Human Immunodeficiency Virus Infection		Malignant Tumor of Prostate		-

Surgeries/Other:

☐ *Check here if NONE of the above are applicable*

SKIN CONDITIONS – please ✓ all that apply.

	Acne		Contact Dermatitis due to Poison Ivy		H/O: Hay Fever		Squamous Cell Carcinoma
	Actinic Keratosis		Dysplastic Nevus of Skin		Malignant Melanoma		Sun Burn of Second Degree
	Asteatosis Cutis		Eczema		Pruritus of Scalp		
	Basal Cell Carcinoma of Skin		H/O: Asthma		Psoriasis		

Other:

☐ *Check here if NONE of the above are applicable*

SKIN PROTECTION – please be sure to specify the SPF level.

	Decline	YES	NO
Sun / UV Exposure			
Do you wear sunglasses?			
Do you use sunscreen?		If yes, what SPF? _________	
Do you use tanning beds or lotions?			

FAMILY H/O MELANOMA – and relationship to you – parent(s), sibling(s) or grandparent(s):

Disease/Condition	Parent/Sibling/Grandparent
Basal Cell Carcinoma	
Squamous Cell Carcinoma	
Melanoma	
	☐ *Check here if NONE of the above are applicable*

MEDICATION & VITAMIN HISTORY: -- please list what you are taking, dosage strengths and how often.

We can attach your list if you brought it.		
		☐ *Check here if NO medications or vitamins*

ALLERGIES: ____

____

____ ☐ *Check here if NO ALLERGIES*

Are you allergic to: Latex ☐ Yes ☐ No OR Lidocaine ☐ Yes ☐ No

SMOKING HABITS – please check all that apply.

	Current every day smoker		Never smoker
	Current some day smoker (chewing tobacco)		Cigar smoker
	Current some day smoker (cigarette)		Heavy tobacco smoker
	Former smoker		Light tobacco smoker

☐ *Check here if NONE of the above are applicable*

ALCOHOL & DRUG USE – please check all that apply.

	Yes	No	Decline
Do you consume alcohol? (EtOH or grain alcohol)?	If yes, how many drinks a day? _______________		
Do you use illicit drugs?			

☐ *Check here if NONE of the above are applicable*

OTHER SOCIAL HISTORY – please check all that apply.

	Yes	No	Decline
Are you sexually active?	If yes, please specify if it is one partner or multiple, ______________________		
Do you have driving restrictions?	If yes, please specify if they are for during the day, night, or both, _____________________________		
Do you feel safe at home?			

☐ *Check here if NONE of the above are applicable*

YAG-HOWARD
COSMETIC DERMATOLOGY

AREA(S) OF INTEREST – please ✓ all that apply**:**

	COSMETIC
	Fine lines & wrinkles on my forehead /around my eyes
	Deep lines or wrinkles around my mouth / cheeks
	Hollow cheeks / thinning facial shape
	Thinning lips
	Red veins on my face
	Brown spots on my face, neck and/or chest
	Sagging skin on my lower face and / or neck
	Crepey skin on my neck and / or chest
	Spots or crepey skin on my hands, arms or legs
	Toxins and/or dermal fillers
	Halo laser or other Laser / Light treatment (BBL/IPL)
	Sofwave skin tightening
	HydraFacial, SkinPen microneedling or Chemical Peel
	Other:

	MEDICAL
	Medical skin exam (Total Body Skin Exam)
	Rash or skin irritation
	Skin cancer concern or follow-up
	Melanoma or skin cancer history
	Moles or suspicious spots
	Skin tags or raised tan-colored moles
	Ingrown hair or nail concern
	Acne
	Hairloss
	Skin discoloration
	Other:

HIPAA CONSENT (Health Insurance Portability and Accountability Act of 1996)**:**
In connection with the medical services that I am receiving from Yag-Howard Dermatology Center and its medical staff, I hereby authorize Yag-Howard Dermatology Center, its practitioners, and their respective agents to disclose any and all information concerning my medical condition and treatment (including, but not limited to super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, DNA samples or analyses, or other such information), including copies of applicable hospital and medical records to:

A. any third-party payor covering the medical services of the patient;
B. other health care professionals and institutions involved in the delivery of health care to the patient;
C. the proponent of any legally sufficient subpoena, or in response to a court order;
D. employees and agents of the practice, to the degree necessary to facilitate the provision of health care operations, services and payment for such services;
E. pharmacies; and as otherwise required by law.

Signature: ____

PHOTO CONSENT:
I further consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my practitioner and under such conditions and at such times as may be approved by my provider.
2. The photographs shall be taken by my practitioner or by a photographer approved by my provider.
3. The photographs shall be used for medical records only.
4. The aforementioned photographs may be modified or retouched in any way that my provider, in his/her discretion, may consider desirable.

Signature: ____

This consent is valid from the date executed until revoked in writing by the patient.

Signature: ____

IF YOU ARE NOT THE PATIENT, what is your Name & Relationship: ____