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PATIENT DEMOGRAPHICS

First Name_____ MI:_____ Last Name:_____ Suffix:_____ Nickname:_____

Home Address: _____ City: _____State:_____ Zip:_____

Billing Address: _____ City: _____ State:_____ Zip:_____

DOB: _____/_____/_____ PHONE: Home #: (_____) _____-_____ Cell #: (_____)_____-_____

PCP or Referring Physician: _____ Employer: _____

Soc. Sec. Number: _____-_____-_____ Gender: _____ Marital Status: _____

Race: (Check all that apply)
- ☐ American Indian
- ☐ Asian
- ☐ Black/ African American
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ White

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other _____

EMAIL ADDRESS _____

(By providing your email address, you are consenting to receive Shelby Dermatology updates, offers, and access to your patient portal, from which you can unsubscribe at any time.)

RESPONSIBLE PARTY | GUARDIAN INFORMATION

If same as above check here: ☐

Person Responsible for Account:_____ Relationship:_____

Billing Address:_____ City: _____ State:_____ Zip:_____

PHONE Home #: (_____)_____-_____ Cell #: (_____)_____-_____Email: _____

INSURANCE POLICY INFORMATION

1st Insurance:_____ Contract #:_____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____/_____/_____ Relationship of patient to policy holder _____

2nd Insurance:_____ Contract #:_____ Group #:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____/_____/_____ Relationship of patient to policy holder _____

3rd Insurance:_____ Contract #:_____ Group #:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____/_____/_____ Relationship of patient to policy holder _____

SMOKING STATUS

- ☐ Never Smoked
- ☐ Current every day smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Former smoker

If you have ever smoked, what year did you begin smoking? _____

If you are a former smoker, what year did you quit smoking? _____

Initials _____

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DRUG ALLERGIES | MEDICATIONS

Do you have any known DRUG allergies?

- ❑ Lidocaine
- ❑ Other _____

_____

_____

_____

_____

Current oral and topical Medications?

_____

_____

_____

_____

_____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:

Name _____ Phone (_____) _____ - _____ Relationship to Patient_____

ADDITIONAL CONTACT INFORMATION

Preference for appointment reminders?

- ❑ Phone
- ❑ Text Message

If we call by phone, may we leave a message with personal information including test results on your Voicemail? **Y** **N**

May we discuss **appointment confirmation, lab/biopsy results, or any relevant medical information** with family members or friends? **Y** **N**
If yes, please list below:

_____
First Name Last Name Relationship Phone Number

_____
First Name Last Name Relationship Phone Number

PHARMACY

Name: _____ Street/City:_____

Phone: (_____) _____-_____ Zip code: _____

Initials _____

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WHO CAN WE THANK FOR YOUR VISIT TODAY?

- ❑ Physician Referral _____
- ❑ Word of Mouth _____
- ❑ Internet Search Engine (Google, Chrome, etc)
- ❑ Insurance Website (BCBS, Aetna, etc)
- ❑ Advertisement _____
- ❑ Other _____
- ❑ Phone Book
- ❑ Social Media
  - o Facebook
  - o Pinterest
  - o Instagram
  - o Other_____

PATIENT POLICIES AND NOTICES

Guarantee of Payment
In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay Aesthetic Dermatology | Shelby Dermatology, insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees, and court costs if such be necessary, waiving now and forever the right of accept insurance assignment as a guarantee of full payment.

_____ **(PLEASE INITIAL)**

Assignment of Insurance Benefits and Release of Information
My signature below authorizes my insurance company to mail payment of authorized benefits for any medical services rendered directly to Aesthetic Dermatology | Shelby Dermatology. Furthermore, my signature below authorizes Aesthetic Dermatology | Shelby Dermatology to release to my insurance company medical information regarding his treatment for the purposes of determining eligibility for and payment of charges for services rendered in connection with care.

_____ **(PLEASE INITIAL)**

Aesthetic Dermatology | Shelby Dermatology reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment**.**

_____ **(PLEASE INITIAL)**

ePrescribing
Aesthetic Dermatology | Shelby Dermatology has implemented ePrescribing. ePrescribing sends your prescriptions over the internet to your pharmacy; keeping your personal information protected. ePrescribing also lets your doctor see important information- like drug interactions and your prescription history. I authorize, with the signature below, that Aesthetic Dermatology | Shelby Dermatology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes through ePrescribing software.

_____ **(PLEASE INITIAL)**

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information
I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that Aesthetic Dermatology and Shelby Dermatology, PC may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization. Aesthetic Dermatology and Shelby Dermatology, PC have a detailed document called the '*Notice of Privacy Practices'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Aesthetic Dermatology and Shelby Dermatology, PC will provide me with the most current *Notice of Privacy Practices.* My signature below indicates that I have been given the chance to review such a copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Aesthetic Dermatology and Shelby Dermatology, PC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Aesthetic Dermatology and Shelby Dermatology, PC has taken action relying on this consent.

_____ **(PLEASE INITIAL)**

Patient or Responsible Party Signature: _____ **Date** _____/_____/_____

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Aesthetic Dermatology | Shelby Dermatology Media and Photography Release Form

Patient Name _____ Date _____

I am: ☐ The individual named above

☐ The individual's parent/guardian/ legally authorized personal representative

I consent for medical photographs or videos to be taken of me/ my child/ the person for whom I am legally authorized to represent. I understand that the information may be used in my personal medical record, for purposes of medical teaching, or for informative medical media purposes via website or in office telecommunications and publications. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

Erin Fisher, Practice Administrator
Phone: (205) 621-9500
Email: efisher@shelbydermatology.com

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

I HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I HAVE GIVEN UP RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.

_____ _____
(Signature) (Witness)

**Any photographs or videos taken by Aesthetic Dermatology | Shelby Dermatology will be obtained by the use of a camera or video recording device dedicated specifically for the above explained purposes. It will be maintained in a secure location and cleared of its memory after images are uploaded. At NO time will personal devices, such as cell phones, be used to obtain photographs or videos for use by Aesthetic Dermatology | Shelby Dermatology.*

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Patient Name: _____

Are you interested in advanced skin care products that have been researched and personally arranged by Drs. Henderson, Bourgeois and Northington? Y ☐ N ☐

If yes, check the following skin care system(s) that you would like information on:

☐ Acne Kit ☐ Aging Kit ☐ Men's Kit ☐ Pregnancy Kit ☐ Oily Skin Kit
☐ Dry Skin Kit ☐ Antioxidant Kit ☐ Post Laser Kit ☐ Scar Kit ☐ Eyelid Kit
☐ Cleansing Kit ☐ Sunscreen Kit

Interested in Learning More About:

☐ BOTOX
☐ Brown Spots/Age Spots/Freckles
☐ Chemical Peels
☐ Facial Fullness/Drooping
☐ Facial Redness/Veins
☐ Facials
☐ Fillers (i.e Juvederm)
☐ Fine Lines/Wrinkles
☐ Hand Rejuvenation
☐ HydraFacials
☐ Laser Hair Removal
☐ Leg Veins
☐ Liposuction
☐ Make-up
☐ Scar Treatment
☐ Tightening of the facial, neck, and chest

☐ **Please enroll me in the following aesthetic reward programs.**

Brilliant DISTINCTIONS® PROGRAM

ASPIRE GALDERMA REWARDS

SKINCEUTICALS ADVANCED PROFESSIONAL SKINCARE

☐ **I would like to receive information on upcoming events and new skin care treatments**