**Patient Intake Form**

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| **Date** | | |  | | **Date of Birth** | | | | | |  | | **Occupation** | | | | | |
| **First Name** | | |  | | | | **Last Name** | | | | | | | | |  | **Preferred Name** | | | |
| **Home Phone** | | |  | | | | **Cell phone** | | | | | | | | |  | **Work Phone** | | | |
| **Allow us to leave detailed voice messages if unable to reach you?** | | |  | | | **YES** | | |  | **NO** | | | | **Email** | | | | | | | |
| **Preferred Phone** | | |  | | | **Home** | | |  | **Cell** |  | **Work** | | | | **Any** | | |  |

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|  | | | | | | | **Male** | | **Female** | **Non-Binary** |
|  | | | | | | |  | |  |  |
| **Height** | | | **Birth Gender** | | | □ | | □ |  |
| **Weight** | | **Gender Identity** | | | | □ | | □ | □ |
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| **Address** | | | | | | | | | | | |
| **City** | |  | | | **State** |  | | **Zip Code** | | | |

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| **Insurance Subscriber/Policy Holder**  (If different from patient) |  | **Relationship** |  | **DOB**  (Subscriber) |  | **SSN**  (Tricare only) |

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| **Reason for Visit:** |
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|  | | **Yes** | **No** |
| **Do you have any cosmetic or antiaging concerns?** |  | □ | □ |
| **Have you had any cosmetic or antiaging treatments in the past?** | □ | □ |

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| **Primary Care Provider** | |  | **Phone** | |  | **Fax** | |
|  | |  | |  |  | | |  | |
| **Referring Provider** | |  | **Phone** | |  | **Fax** | |
| **Pharmacy Name/Location** | |  | **Phone** | |  | **Fax** | |

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| **Medications** (Including prescribed, supplements, and herbs)  By checking this box, I give consent for Empire Dermatology to obtain all information about my medications from my pharmacy. | |
| **No medications** | **□** |
| **Medication list attached** | **□** |

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| **Medication name** | **Dose** (if known) | **Frequency** |
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| **Medication Allergies** | | |
| **No known drug allergies □** | |  |
| **Allergy name** | **Type of Reaction** | |
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**Cancellations & No-Show Fee**

Empire Dermatology has a 24-hour cancellation and no-show policy. Patients who do not show for their appointment or cancel within 24-hours of the scheduled appointment time are subject to a $25 fee for general dermatology and $100 fee for cosmetic and procedures. **These fees are not covered by insurance.**

**Pathology Fees**

Depending upon specific factors, your provider may send a specimen to an outside lab for slide processing and interpretation. In those cases, patients or their insurance company will receive a bill from an outside lab. A list of labs used are located throughout the office and can be provided to patient upon request.

**Benign Lesions**

Patients are financially responsible for the removal or treatment of all benign skin lesions unless they have met certain clinical criteria, including, but not limited to change in quality or character, increase in size, pain, or bleeding. Billing insurance for such circumstances may represent fraud.

**Copays**

Due to insurance requirements, copays are due at the time of service. If you are not able to pay your mandatory copay, you will be required to reschedule your appointment.

**Appointment Reminders**

Empire Dermatology will send appointment reminders as a courtesy to our patients. The appointment reminders can be sent via text, voice, and email messages. You can opt out by replying to the reminder message.

**By signing below, I acknowledge and will comply with the information given above.**

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| **Patient Name** (Print) |  | **Signature** |  | **Date** |

**Acknowledgement of Receipt**

I acknowledge that I have read and/or was given the opportunity to read a copy of the Empire Dermatology notice of privacy practices.

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| **Patient Name** (Print) |  | **Signature** |  | **Date** | |

If completed by a patient’s legal guardian or personal representative, please print, and sign your name and state your relationship to the patient below:

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|  |  |  |
| **Representative Name** (Print) |  | **Signature** |
| **Relationship to Patient** |  |  |

I give Empire Dermatology permission to discuss my medical information with:

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| **Names of family members/friends/providers not listed previously**  (Optional) |

**Credit Card Authorization Form**

**For all appointments moving forward, we require a card on file to provide touchless, simple transactions. Your card will not be charged without notifying you beforehand.**

**Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.**

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| **Credit Card Information** | | |
| Card Type: □ Master Card □ VISA □ Discover □ AMEX  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Cardholder Name (as shown on card):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Last 4 Digits of  Card Number:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Expiration Date  (MM/YYYY):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cardholder ZIP Code (from credit card billing address):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**□ I prefer to give my information directly to the receptionist**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Empire Dermatology to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.**

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| **Customer Signature** |  | **Date** |