

Board Certified Dermatologists

James Seward, MD
Elizabeth Grattan, MD
Jocelyn LaRocque, DO
Lesslie Durst, PA-C
Lisa Matuga, PA-C
Keri Squittieri, PA-C



15830 Ballantyne Med. Pl, Ste 100,
Charlotte, NC 28277

6040 W. Hwy 74, Indian Trail, NC
28079

11304 Hawthorne Dr. Ste 110,
Mint Hill NC 28227

704-341-0090/ 704-341-0092 (F)

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____

Mailing Address: _____

City: _____

State: _____ Zip: _____

Gender: Male Female SSN: _____

Marital Status: _____ Date of Birth: ____/____/____

Race: American Indian/Alaskan Native Caucasian

Asian Pacific Islander African American Decline

Ethnicity: Hispanic Non-Hispanic Decline

Home Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____ Ext: _____

Personal Email address: _____

HOW DID YOU HEAR ABOUT US?

Physician Family Friend Yellow Pages

Insurance Co. Internet Newspaper Other

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Phone #1: (____) _____ Phone #2: (____) _____

Relationship to Patient: _____

PHARMACY INFORMATION

Name: _____

Location: _____

Phone #: _____

By signing below, I authorize Dermatology Care of Charlotte, to leave messages in reference to any items that assist in carrying out healthcare operations.

Home Phone: Yes No Cell Phone: Yes No Work Phone: Yes No Patient Portal: Yes No

Please list any persons to whom your protected health information can be disclosed to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient or Responsible Party Signature: _____ Date: _____

PARENT/GUARDIAN IF PATIENT UNDER 18 YEARS OF AGE

Name: _____

Date of Birth: _____ Phone: (____) _____

Address: _____

PRIMARY INSURANCE INFORMATION

Policyholder: _____

Relationship to Patient: _____

Date of Birth: ____/____/____

Daytime Phone # : (____) _____

Address: _____

SECONDARY INSURANCE INFORMATION

Policyholder: _____

Relationship to Patient: _____

Date of Birth: ____/____/____

Daytime phone # : (____) _____

Address: _____

PATIENT EMPLOYMENT INFORMATION

Employment Status: Employed Student Self-employed Retired
Company: _____

PHYSICIAN REFERRAL INFORMATION

Referred By: _____

Practice Name: _____

Board Certified Dermatologists

James Seward, MD
Elizabeth Grattan, MD
Jocelyn LaRocque, DO
Lesslie Durst, PA-C
Lisa Matuga, PA-C
Keri Squittieri, PA-C



15830 Ballantyne Med. Pl, Ste 100
Charlotte, NC 28277

6040 W. Hwy 74, Indian Trail, NC
28079

11304 Hawthorne Dr. Ste 110,
Mint Hill NC 28227

704-341-0090/ 704-341-0092 (F)

MEDICAL HISTORY FORM

Name: _____ Date: _____ Age: _____

Reason for Visit: _____

Referred By: _____ Primary Care Physician: _____

Allergies: (please list any drugs and type of allergic reaction) NONE Tape Antibiotic Creams Latex

Current Medications (including over the counter): NONE (include dosage, frequency and route of administration if known)

Pregnancy: Are you pregnant? Yes No Breastfeeding Yes No Are you planning a pregnancy in the future? Yes No

Medical History: NONE (Please list any current or past medical conditions or cancers, including skin) :

Family History: NONE Melanoma Asthma Allergies/Hay-fever Thyroid Disease Hair Loss Other: _____

*Please Specify Affected Family Member/s: Father Mother Brother Sister Son Daughter

Social History: Occupation: _____
Alcohol use: (list drinks per week) _____ Tobacco use: (list packs per day) _____

Major Surgeries and Hospitalization: NONE

Date _____ Date _____

Date _____ Date _____

Date _____ Date _____

Do you have any of the following? Please check any positive answers:

- | | |
|--|--|
| Const: <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss | Neuro: <input type="checkbox"/> Weakness <input type="checkbox"/> Dizziness <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of skin sensation |
| Eyes: <input type="checkbox"/> Blurred vision <input type="checkbox"/> Sensitivity to light | Heme: <input type="checkbox"/> Easy bruising, <input type="checkbox"/> Excessive bleeding |
| CV: <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Feet and leg swelling <input type="checkbox"/> Varicose veins | Endo: <input type="checkbox"/> Hair loss <input type="checkbox"/> Excessive hair growth <input type="checkbox"/> Dark color in skin <input type="checkbox"/> Significant stretch marks |
| GU: <input type="checkbox"/> Genital lesions | <input type="checkbox"/> Excessive sweating |
| MS: <input type="checkbox"/> Joint aches <input type="checkbox"/> Muscle aches <input type="checkbox"/> Joint stiffness | Allergy: <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Hives |
| Skin: <input type="checkbox"/> Itching, <input type="checkbox"/> Sensitivity to light <input type="checkbox"/> Rash | Psy: <input type="checkbox"/> Depression <input type="checkbox"/> Suicidal thoughts |

Cosmetic Interest: Can we provide you with further information on any of the following services?

- | | | |
|--|---|---|
| <input type="checkbox"/> Botox (for facial wrinkles) | <input type="checkbox"/> Latisse (for longer, fuller lashes) | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Peels / Facial Rejuvenation | <input type="checkbox"/> Skin Tag / Mole Removal | <input type="checkbox"/> Brown Spot Reduction / Removal |
| <input type="checkbox"/> Leg Spider Vein Treatment | <input type="checkbox"/> Facial Spider Vein Treatment | <input type="checkbox"/> Hair Loss Treatment |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Facial Rejuvenation with Injectable fillers (Juvederm, etc.) | |

Patient or Patient's Representative Signature: _____ Date: _____

Board Certified Dermatologists

James Seward, MD
Elizabeth Grattan, MD
Jocelyn LaRocque, DO
Lesslie Durst, PA-C
Lisa Matuga, PA-C
Keri Squittieri, PA-C



15830 Ballantyne Med. Pl, Ste
100 Charlotte, NC 28277

6040 W. Hwy 74, Indian Trail, NC
28079

11304 Hawthorne Dr. Ste 110,
Mint Hill NC 28227

704-341-0090/ 704-341-0092 (fax)

Financial Policy for All Patients, including Medicare:

Dermatology Care of Charlotte (DCC) is considered a specialist office. Some insurance policies require that prior to your office visit; you must obtain a referral from your primary care physician. If this is not acquired prior to your visit, you may be asked to reschedule your appointment or pay for your visit in full.

Payment is required for all services at the time they are rendered unless you are covered under an insurance policy in which we participate. For those patients, applicable co-payments, deductibles, and/or coinsurance will be collected at the time of service. The patient is responsible for any/all charges not paid for by their insurance company.

I have read and understand the financial policy statement. I agree to make prompt payment in full to DCC when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered (i.e. cosmetic services). Further, I authorize payment directly to DCC for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. This authorization is valid until revoked in writing.

Signature: _____

Date: _____

Privacy Practices (HIPAA):

Receipt of Privacy Practices

By signing below, I acknowledge that I have the right to review a copy of the Notice of Privacy Practices prior to signing this consent. I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Signature: _____

Date: _____

Additional Financial Policy for Medicare Patients Only:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Signature: _____

Date: _____

Permission to Treat a Minor- Only for Patients age 18 or younger:

A parent or guardian must be present with a patient under the age of 18 for the first visit and any subsequent visit in which a procedure is performed. The parent/ guardian grants permission to DCC to see the minor without their presence for standard medical office visits. This authorization is valid until revoked in writing. I have legal right to select and authorize health care services for this minor child.

Signature: _____

Relationship to Patient: _____

Date: _____