Board Certified Dermatologists

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

Dermatology Care of Charlotte
www.dermcarecharlotte.com

15830 Ballantyne Medical Place
Suite 100
Charlotte, NC 28277
704-341-0090/ 704-341-0092 (fax)

6040 W. Hwy 74, Indian Trail, NC
704-821-0615/ 704-341-0092 (fax)

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 #:_____

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: _____

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:** _____

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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: ☐Chills ☐Fatigue ☐Fever ☐Weight gain ☐Weight loss
Eyes: ☐Blurred vision ☐Sensitivity to light
CV: ☐Rapid heart beat ☐ Feet and leg swelling ☐Varicose veins
GU: ☐Genital lesions
MS: ☐Joint aches ☐ Muscle aches ☐Joint stiffness
Skin: ☐Itching, ☐Sensitivity to light ☐Rash

Neuro: ☐Weakness ☐Dizziness ☐Tingling ☐Loss of skin sensation
Heme: ☐Easy bruising, ☐Excessive bleeding
Endo: ☐Hair loss ☐Excessive hair growth ☐Dark color in skin ☐Significant stretch marks ☐Excessive sweating
Allergy: ☐Seasonal allergies ☐Hives
Psy: ☐Depression ☐Suicidal thoughts

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

☐Botox (for facial wrinkles)
☐ Peels / Facial Rejuvenation
☐ Leg Spider Vein Treatment
☐Laser Hair Removal
☐Latisse (for longer, fuller lashes)
☐ Skin Tag / Mole Removal
☐ Facial Spider Vein Treatment
☐Facial Rejuvenation with Injectable fillers (Juvederm, etc.)
☐Skin Care Products
☐ Brown Spot Reduction / Removal
☐ Hair Loss Treatment

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

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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:_____