Board Certified Dermatologists
James Seward, MD
Elizabeth Grattan, MD
Jocelyn LaRocque, DO
Lisa Matuga, PA-C
Keri Squittieri, PA-C
Mary Cummins, PA-C

Dermatology Care of Charlotte
www.dermcarecharlotte.com

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:**_____

Date of Birth: ____/____/_____ **Gender:** ☐Male ☐Female

Marital Status: _____ **SSN:**_____

PARENT/GUARDIAN IF PATIENT IS UNDER 18

Name:_____

Date of Birth:_____ **Phone:** (_____)_____

Address: ☐ **Check Here if Same as Patient's**_____

_____

EMERGENCY CONTACT INFORMATION

Emergency Contact:_____

Phone: (_____)_____

PHARMACY INFORMATION

Name:_____

Location: _____

Phone: (_____)_____

PATIENT CONTACT INFORMATION

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____ **Ext:**_____

Email address: _____

Mailing Address:_____

Apartment Number:_____

City: _____

State:_____ **Zip:**_____

HOW DID YOU HEAR ABOUT US?

☐**Physician** ☐**Family** ☐**Friend** ☐**Yellow Pages**

☐**Insurance Co.** ☐**Internet** ☐**Newspaper** ☐**Other**

DOCTOR REFERRAL:

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 of Birth:**_____ **Age:**_____

Reason for Visit: _____

Referred By:_____ **Primary Care Physician:**_____ **Alcohol Use (drinks/week):** _____

PAST MEDICAL HISTORY: Circle Yes or No ☐ **No known Past Medical History** **Tobacco Use (packs/day):** _____

CONDITION	PATIENT	CONDITION	PATIENT	CONDITION	PATIENT
Anxiety	Yes No	Coronary Artery Disease	Yes No	High Cholesterol	Yes No
Arthritis	Yes No	Depression	Yes No	Hyperthyroidism	Yes No
Asthma	Yes No	Diabetes	Yes No	Hypothyroidism	Yes No
A Fib (irregular heartbeat)	Yes No	End Stage Renal Disease	Yes No	Leukemia	Yes No
BPH (enlarged prostate)	Yes No	Hepatitis	Yes No	Lymphoma	Yes No
Cancer, Specify:	Yes No	High Blood Pressure	Yes No	Seizures	Yes No
COPD	Yes No	HIV/AIDS	Yes No	Stroke	Yes No

PAST SURGICAL HISTORY: Check if you have had the following. ☐ **No Surgeries** ☐ **Other:** _____

□ Appendectomy	□ Colostomy	□ Knee Replacement	□ Ovarian Cancer	□ Spleen Removal
□ Bladder Removal	□ Gallbladder Removal	□ Hip Replacement	□ Ovarian Cyst	□ Testicles Removed
□ Lumpectomy	□ Biological Valve Replacement	□ Kidney Transplant	□ Tubal Ligation	□ Fibroids
□ Mastectomy	□ Bypass Surgery	□ Liver Transplant	□ Pancreatectomy	□ Uterine Cancer
□ Colon Cancer Resection	□ Heart Transplant	□ Endometriosis	□ Prostatectomy	□ Cervical Cancer

SKIN HISTORY: Have you ever had any of the following? ☐ **No Skin Condition History**

□Acne	□Basal Cell	□Eczema	□Melanoma	□Seborrheic Keratosis
□Actinic Keratosis	□Blistering Sunburns	□Flaking or Itchy Scalp	□ Precancerous Moles	□Squamous Cell
□Asthma	□Dry Skin	□Hay Fever/Allergies	□ Psoriasis	□Other:

CURRENT MEDICATIONS (including over the counter): ☐ NONE (include dosage, frequency and route of administration if known)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

ALLERGIES: (please list any drugs and type of Reaction) ☐NONE ☐Tape ☐Antibiotic Creams ☐ Latex ☐ Numbing Medication

_____ _____ _____ _____

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

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

REVIEW OF SYSTEMS: Have you had any of the following in the past year? Please Check any Positive Answers:

Const: ☐Chills ☐Fatigue ☐Fever ☐Weight gain ☐Weight loss

Eyes: ☐Blurred vision ☐Sensitivity to light

CV: ☐Rapid heartbeat ☐ 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) ☐Latisse (for longer, fuller lashes) ☐Skin Care Products
☐ Chemical Peels ☐ Skin Tag/Mole Removal ☐ Brown Spot Reduction/Removal
☐ Spider Vein Treatment ☐Facial Rejuvenation with Injectable fillers (Juvederm, etc.) ☐ Hair Loss Treatment
☐Laser Hair Removal

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:_____