Annie Chiu, M.D.
THE DERM INSTITUTE

PATIENT INFORMATION AND MEDICAL HISTORY FORM

PATIENT DEMOGRAPHICS

Preferred Called Name: _____ Age: _____ Date of Birth: _____

Last Name: _____ First Name: _____ MI: _____

CONTACT INFORMATION

Phone: _____ Cell: _____ Txt Msg OK: ☐ Yes ☐ No

May we leave a detailed message? ☐ Yes ☐ No If YES, please circle preferred number.

Email: _____

May we email you for appointment reminders, confidential results, promos, etc? ☐ Yes ☐ No

ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

EMPLOYMENT

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to patient: _____

FINANCIALLY RESPONSIBLE PARTY (Complete if NOT SELF/Patient is a MINOR)

Last Name: _____ First Name: _____

Relationship to patient: _____ Date of Birth: _____

Address: _____ Phone: _____

PRIMARY PHYSICIAN

Physician Name: _____ Physician Phone: _____

Physician Address: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

REFERRAL

How did you hear about us? (If physician/friend, please list name

_____

PATIENT MEDICAL HISTORY

Reason for Today's Visit _____

KEY PAST MEDICAL HISTORY (please check all that apply)

☐ Anxiety ☐ Cancer (type): _____ ☐ Hyperthyroid / Hypothyroid

☐ Arthritis ☐ Hepatitis, Type: _____ ☐ Radiation Treatment or History

☐ Asthma ☐ Hypertension (high blood pressure) ☐ Seizures

☐ Diabetes ☐ HIV+ / AIDS ☐ NONE

OTHER (please check all that apply)

☐ Reaction to Local Anesthetic ☐ Keloid Scarring ☐ Cold Sores / Oral Herpes

☐ Blood Clots ☐ Stomach Ulcer History ☐ Organ Transplant _____

Other Health Conditions: _____

PAST SURGERIES: _____

SKIN CONDITION HISTORY (please check all that apply)

☐ Actinic Keratosis ☐ Hayfever/Allergies ☐ Squamous Cell Skin Cancer

☐ Basal Cell Skin Cancer ☐ Melanoma ☐ NONE

☐ Blistering Sunburns ☐ Precancerous Moles ☐ Other: _____

GENERAL SKIN QUESTIONS (please check all that apply)

Wear Sunscreen, SPF: _____ History of Tanning Salon Use: ☐ Yes ☐ No ☐ Current

Has a Relative Had Melanoma? ☐ Yes ☐ No If Yes, which relative(s): _____

CAUTIONS (please check all that apply)

☐ Difficulty Stopping Bleeding ☐ Pacemaker / Defibrillator ☐ Metal Implants/Screws

☐ Antibiotic for Dental Procedures ☐ Artificial Joint _____ ☐ Artificial Heart Valve

☐ **Fainting with Procedures** ☐ **(WOMEN)** Pregnant, Trying, Nursing

ALLERGIES

Medication Allergies (please list): _____ Latex Allergy: ☐ Yes ☐ No

MEDICATIONS

Prescription Medications (please list): _____

Over-the-counter medications (please list): _____

SOCIAL HISTORY (please check all that apply)

☐ Currently Smokes ☐ Smoked in the Past ☐ Drug Use: _____

Patient Signature: _____ Date: _____

Patient Name (Print): _____

I certify I have completed this form in its entirety, and the above is true and correct.

(CLINIC USE: REVIEWED _____)

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Acknowledgement of Privacy and Consent

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed and understood the Notice of Privacy Practices. I know I have a right to obtain a copy for my records.

Patient Signature: _____

Patient Name (print): _____ Date:_____

Consent for Evaluation, Examination, and Treatment

By signing below, I authorize the evaluation, examination, and treatment by Dr. Chiu and her staff. I consent to treatment necessary for my dermatologic care. Skin growths may be treated by freezing, cortisone injections, snip removal, extractions and/or electrocautery with a heated needle. A skin biopsy (taking a small sample of skin under local anesthesia) may be used for diagnosis. I understand I can refuse any procedure.

I understand that there are risks to any procedure, including, but are not limited to:

- Bleeding
- Pain
- Infection
- Scar
- Discoloration (temporary or permanent)
- Rarely, nerve damage

I consent to having these procedures done as part of my evaluation and treatment.

By signing below, I also understand the following:

- Total body examinations for skin cancer screening are performed if specifically scheduled in advance, as this may require additional time.
- I understand that most clinic visits are scheduled for consultation of a specific skin condition. Procedures, even minor removals, usually need to be scheduled at a separate time. The Derm Institute will try to accommodate procedures if time permits.
- I am aware that there are potential risks to any treatment or medication (oral or topical) prescribed. Dermatological conditions are often chronic in nature and may require ongoing care and for me to schedule follow up appointments.

This authorization and consent shall remain in force for this and all future visits to The Derm Institute.

Patient Signature _____

Patient Name (Printed) _____ Date:_____

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Financial Policy

Payment is required for all services at the time they are rendered. The Derm Institute is not currently accepting any commercial insurance plans. Any consultations for medical or cosmetic issues will have an associated consultation fee collected at the time of your visit. An itemized receipt can be made available at your request.

Applicable payments for *medical* consultations and procedures performed at The Derm Institute will be an out-of-pocket expense and considered out-of-network. Additional tests, i.e. pathology, laboratory, radiologic or other diagnostic tests may be billed separately in addition to the visit.

For your convenience, we accept cash, Visa, MasterCard, American Express, and Discover. CareCredit financing may be used subject to a minimum balance. At your request, a copy of this document can be made available to you.

Regardless of whether you have insurance, THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYING for the services rendered. This contract is between you, the patient, and Annie Chiu, MD, Inc. Claims that you want submitted for any out-of-network benefits will be the responsibility of the patient. A copy of your Health Insurance Claim Form can be made available at your request.

Unless a payment plan has been arranged, all unpaid balances over 30 days will be turned over to a collection agency. You will be responsible for all collection costs, including court/attorney fees, and a 30% collection fee.

Cancellation Policy*: We require a minimum of **48-hour notice** for appointment cancellation. A credit card is required to hold your appointment slot and you will NOT be charged if you provide us 48 hour notice of any appointment changes. **Cancellations, rescheduling, or no-shows to your appointment during the 48-hour window will result in a charge of $250 for the first and second cancellation and $500 for subsequent cancellations which will be charged to the credit card on file.**

Your signature below:

- Signifies your understanding and agreement to above policy, and your responsibility to pay for all applicable fees on the day of service and any outstanding balances.
- Authorizes the release any information, including the records of all visits provided at The Derm Institute, for the purpose of processing your claims for insurance if needed.

Patient/Guardian Signature _____

Patient Name (Printed) _____ Date: _____

*Cancellation Fee subject to change without notice.

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Cosmetic Questionnaire (Optional)

Our goal is to make every patient look and feel as radiant as possible. The Derm Institute is committed to a no-pressure atmosphere where we partner with you to achieve healthy, happy skin.

Tell us if you are interested . . .

- ☐ Skincare Advice
- ☐ Skin Texture/ Skin Laxity Improvement
- ☐ Botox or Other Wrinkle Relaxer
- ☐ Cosmetic Fillers (Restylane, Juvederm, Radiesse)
- ☐ Age Spots/ Uneven Pigmentation
- ☐ Chemical Peels
- ☐ Acne Scars
- ☐ Non-Invasive Body Fat Elimination
- ☐ Non-Invasive Butt Lift
- ☐ Laser Resurfacing/ IPL
- ☐ Redness or Broken Capillaries
- ☐ Pore Size
- ☐ Eyelash Enhancement
- ☐ Spider Vein Treatment

Share with us any specific concerns or areas for improvement . . .

_____

_____

_____

Let us know your current skincare products:

AM Regimen

Cleanser:_____

Serum:_____

Moisturizer:_____

SPF:_____

Topical Rx:_____

PM Regimen

Cleanser: _____

Serum: _____

Moisturizer:_____

Eye Cream: _____

Topical Rx: _____

Tel: 310.939.9800 **www.thederminstitute.com** **Fax: 310.939.9888**