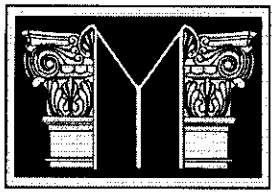

UPTOWN DERMATOLOGY & AESTHETICS

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Full Name: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss _____

Sex: ❑ *Male* ❑ *Female* Date of Birth ____ / ____ / ____ Social Security Number _____ - ____ - _____

Referred By _____ Email Address _____

Marital Status: ❑ *Single* ❑ *Married* ❑ *Divorced* ❑ *Widow/Widower* Spouse _____

Home Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employment: ❑ Full Time ❑ Part Time ❑ Retired ❑ Part Time Student ❑ Full Time Student

Employer or School Name and Address _____

INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARD AND PHOTO ID TO THE RECEPTIONIST

Name of Policy Holder *(if other than the Patient)* _____

Relationship of Patient to Policy Holder: ❑ *Self* ❑ *Spouse* ❑ *Child* ❑ *Other* _____

PAYMENT POLICIES

In order to establish optimal relations with our patients and avoid any misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA, MASTERCARD AND DISCOVER FOR YOUR CONVENIENCE.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims *(if any)*. You herein authorize medical benefits to the Doctor when an assigned claim is filed.

Patient or Legal Guardian Signature _____ Date _____

CORRESPONDENCE

Where should statements of your account be sent if different from above?

Name _____ Address _____

DO WE HAVE PERMISSION TO:

Leave a message on your answering machine at home? ❑ Yes ❑ No

Leave a message at your place of employment? ❑ Yes ❑ No

Discuss your medical condition with any member of your household? ❑ Yes ❑ No

Name _____ Relationship _____

Patient or Legal Guardian Signature _____ Date _____

MEDICARE PATIENTS ONLY: PLEASE SIGN BACK OF THIS FORM WHERE INDICATED

MEDICARE PATIENTS ONLY

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration if a claim. Please read the following statement:

I authorize any holder of medical or other information about me to release-to the Social Security Administration and Health Care Financing Administration 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 the party who accepts assignment. Regulations pertaining to Medicare assignment to benefits apply.

Signature: _____
As it appears on Medicare card

Date: _____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefit payable for related services.

Signature: _____ Date: _____
As it appears on MEDIGAP Card

UPTOWN DERMATOLOGY & AESTHETICS

Patient: _____ Date ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1._____ 2._____

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Do you have now, or have your ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	**YES**	**NO**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**YES**	**NO**
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastroinestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthraigia	❑	❑
Limited motion	❑	❑
Artificial Joint	❑	❑
Convulsions, Epilepsy, or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedure you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing? ❑ YES ❑ NO
Do you develop keloids (scars) after surgery? ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes In reaction to ❑ Medications ❑ Food ❑ Environment?

Social History

Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use drugs? ❑ YES ❑ NO If YES, What?_____ How often?_____
Do-you smoke? ❑ YES ❑ NO If YES, how much: _____
.Have you had or have you been exposed to HIV (AIDS)? ❑ YES ❑ NO

Please answer the following questions:

(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ____/____/____
What is your occupation?_____ Hobbies: _____

Completed by: ❑ Patient
❑ Medical Assistant

_____ Signed by Patient ____/____/____ Date

_____ Initials _____ Reviewed by ____/____/____ Date

Cosmetic Questionnaire

Patient Name: _____ Date: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Preferred Phone: _____ Fax: _____

Email: _____

Address: _____

☐ Approval To send or email Information_____

Patient Signature

Health Issues and procedures or products that interest you (please check all that apply)

☐BOTOX Cosmetic™ (Botulinum Toxin Type A)
☐AHA and Glycolic Peels
☐Collagen Therapy
☐Skin Rejuvenation
☐Retin-A or Renova
☐Chemical Peels
☐Dermal Fillers: Juvederm, Restylane, etc.
☐Birthmarks
☐Sunscreen Advice
☐Facials and Eye Treatments
☐Spider Vein Treatments
☐ Micro-Dermabrasion
☐Acne
☐Skin care Advice/Products
☐Laser Treatments
☐ Laser Resurfacing
☐Liver Spots/ Age Spots
☐Removing Leg Veins
☐ Hair Removal
☐ Removing Facial Veins

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When Looking at my face in the mirror, I Believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

No Show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some of whom are quite ill.

A "no-show" is missing a scheduled appointment. A "late cancellation" is cancelling an appointment without calling us to cancel 24 hours in advance for an office visit or 48 hours in advance for a procedure.

We understand that situations such as medical emergencies occasionally arise in which case adequate notice for a cancellation is not possible. These situations will be considered on a case-by-case basis.

A charge of $200.00 may be assessed for each no-show or late-cancellation for all surgery and/or filler appointments. A 48 hour notice must be given. We have set aside an extended amount of time for these types of appointments.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

_____ _____

Date Signature

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY NOTICE

SHARON S. MEYER, M.D., L.L.C.

3434 PRYTANIA STREET, SUITE 310
NEW ORLEANS, LOUISIANA 70115

SHARON S. MEYER, PRIVACY OFFICER

504-897-5899

I hereby acknowledge that I reviewed a copy of notice of privacy practices.

_____

SIGNED **DATE**

_____

PRINT NAME **TELEPHONE NUMBER**

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient
Guardian or conservator of an incompetent patient
Beneficiary or personal representative of deceased patient

NAME OF PATIENT_____

OFFICE USE ONLY:

Signed form received by: _____

Acknowledge refused: _____

Efforts to obtain: _____

Reasons for refusal: _____