PATIENT INFORMATION

Last Name	First Name		Middle or Maiden	
Social Security #	Sex	DOB	Age	
Home Address	Apt #	City	State	Zip
Home Phone #	Cell Phone #			
Name of Employer	Work Phone #			
Marital Status	Race			

Guarantor (policyholder of primary insurance)

Last Name	First Name		Middle or Maiden	
Social Security #	Sex	DOB	Age	
Home Address	Apt #	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #		
Name of Employer	Employer Address			

Emergency Contact Information

Emergency Contact Name	Relationship to patient	
Mailing Address	Home Phone #	Cell Phone #

Insurance Information

Primary	Secondary
Insurance Co. Name	Insurance Co. Name
Address	Address
City, County, State, Zip	City, County, State, Zip
Insured's Last Name First	Insured's Last Name First
Group Number	Group Number
Policy # or SS #	Policy # or SS #
Relationship to insured	Relationship to insured
Employer	Employer
Phone	Phone

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Carolinas HealthCare System

Carolinas Healthcare Medical Group
PATIENT INFORMATION SHEET

Patient Information or Sticker

Name:

DOB:

Medical Record #:

CMC Cosmetic and Plastic Surgery

1025 Morehead Medical Drive, Suite 200 • Charlotte, NC 28204
Phone (704) 446-6810 • Fax (704) 355-2467

DERMATOLOGY HISTORY

Name: _____ Date: _____

Date of Birth: _____ Drug Allergies: _____

Physician/Primary_____ Specialists: _____

Please answer the following:

- Has area/lesion being seen today been biopsied? ☐ No ☐ Yes If yes what were results? _____

_____

- Has area/lesion being seen today been previously treated (other than biopsy)? ☐ No ☐ Yes If yes, when? _____

_____

- Has area/lesion? ☐ Bled, oozed ☐ Grown in size ☐ Changed color ☐ Itched
  ☐ Changed shape ☐ Not healed ☐ Long time healing
  ☐ Felt irritated

How long has this area/lesion been present? _____

- Have you had any skin cancers (other than the one you are here for today)? ☐ No ☐ Yes If yes:
  Where on the body? _____ How long ago? _____
  What type? _____ How treated? _____
- Does anyone in your family have a history of skin cancer? ☐ No ☐ Yes Who? _____
  What type? _____ How treated? _____
- Do you? ☐ Tan, never burn ☐ Tan, rarely burn ☐ Burn, then tan ☐ Burn, never tan
  Eye Color: _____ Natural Hair Color: _____
- Have you ever: Used a tanning bed? ☐ No ☐ Yes If yes, ☐ Often ☐ Currently
  Had a blistering burn? ☐ No ☐ Yes If yes, how often? _____
  Worked outside? ☐ No ☐ Yes How long? _____
  Had frequent recreational exposure to sun? ☐ No ☐ Yes / How often? _____

Physician Signature: _____ Date: _____ Time: _____

Patient Information or Sticker

Name:

DOB:

Medical Record #:

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For Women:

Are you pregnant? ☐ No ☐ Yes
Do you plan to become pregnant? ☐ No ☐ Yes
Please notify us at any time over the course of treatment if you become pregnant:
☐ I will ☐ N/A because of ☐ Hysterectomy ☐ Tubal Ligation ☐ Post Menopause

Prior Medical History and General Information: (check any and all that apply)

☐ Autoimmune Disease
- ☐ Lupus, Thyroiditis
- ☐ Rheumatoid Arthritis
- ☐ Other: _____

☐ Bleeding/Clotting Problems
☐ Cancer: Location: _____
☐ Diabetes: Controlled by:
- ☐ Injections ☐ Pills ☐ Diet

☐ Heart Disease
- ☐ Arrhythmias, irregular heart beat
- ☐ Murmur +/- antibiotics
- ☐ Heart Attack
- ☐ Heart Surgery: Type: _____
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Stent, when? _____

☐ High Blood Pressure
☐ HIV/AIDS
- ☐ Tested? ☐ No ☐ Yes
- Results: _____
- Date: _____

☐ Kidney Disease
- ☐ Dialysis
- ☐ Other: _____

☐ Liver Disease
- ☐ Hepatitis: ☐ A ☐ B ☐ C
- ☐ Cirrhosis

☐ Lung Disease
☐ Neurological Disease
- ☐ Type: _____

☐ Skin Disease
- ☐ Psoriasis
- ☐ Other: _____

☐ Skin Problems
- ☐ Keloid/Tick Scarring

☐ Stroke/Mini-Stroke
☐ Transplant
- ☐ Kind: _____

☐ Tuberculosis
- ☐ Tested? ☐ No ☐ Yes
- Results: _____
- Date: _____

Any major surgeries? _____

Any joint replacements/internal prosthesis? _____
Any other major/chronic health problems? _____

FOR OFFICE USE ONLY:

Pre-Op antibiotics before dental procedures: ☐ No ☐ Yes If yes, why? _____
Drug List Attached ☐ No ☐ Yes Assistant's Signature: _____
Skin Type: I II III IV Adenopathy: Location: _____
Results: _____

Physician Signature: _____ Date: _____ Time: _____

Patient Information or Sticker

Name:

DOB:

Medical Record #:

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PLEASE READ AND SIGN AT THE BOTTOM THAT YOU UNDERSTAND THE FOLLOWING:

Request for Treatment and Authorization

REQUEST FOR TREATMENT. The hospital maintains personnel and facilities to assist my physicians in providing me medical care, and I authorize the hospital to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment, together with an explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the hospital and its personnel are not responsible for providing me this information. I choose to receive the services even if my insurance plan may not cover specific services, including the specific services rendered during the admission.

Insurance Assignment and Release

I certify that I have insurance coverage with: _____
(Name of Insurance Company (ies)

and assign directly to the Charlotte-Mecklenburg Hospital Authority (CHS). All insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions.
The above named facility may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Notice of Privacy Practices

We are required by law to provide you with you Notice of Privacy Practices which explains how we use and disclose you health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

☐ I have been provided a copy of CHS' Notice of Privacy Practices.

Consent to Photograph

I understand that, as part of my care and treatment, or the care and treatment of another person for whom I have legal authority to consent, photographs will be taken prior to and following the procedure. I understand that this is part of the normal course of treatment and that these photographs will become part of the medical record. They will be kept confidential, except that they may be used for educational or scientific purposes. They will not be used for marketing purposes without my express consent.

☐ I do consent and agree to the terms regarding photographs

☐ I **do not** consent and agree to the terms regarding photographs

By signing below, I affirm that I have read and understand this form in its entirety and agree to be bound by all terms and conditions herein. If I am signing on behalf of another person, I affirm that I have the legal ability to consent on that person's behalf.

Patient's Name (Please Print): _____

Signature of Responsible Party: _____ Date: _____

Patient Information or Sticker

Name:

DOB:

Medical Record #:

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Financial Policy

In order for CMC Cosmetic and Plastic Surgery to continue providing quality care to its patients, it must receive payment for services rendered. PLEAS READ AND SIGN THIS FINANCIAL POLICY STATEMENT.

1. PAYMENT IS EXPECTED ON THE DAY OF YOUR OFFICE VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. PLEASE COME PREPARED TO PAY FOR THE SERVICES YOU RECEIVE.

2. If your insurance is to pay for your visit, and you belong to an HMO policy, your primary care physician must authorize your visit before you can be seen. At the time of your visit, a copy of that authorization must be presented.

3. The charges made for your visit depend on the nature and the complexity of your problem. If you have any questions regarding the charges made for any visit, please direct them to the Central Billing Office at (704) 393-4808.

4. If you decide to have procedures preformed or services rendered which are non-covered procedures or services under your insurance policy, you agree to pay Carolinas Cosmetic and Plastic Surgery directly for those charges in advance.

5. There will be a $25.00 service charge on all returned checks.

I have read, understand and agree to abide by the Financial Policy of CMC Cosmetic and Plastic Surgery.

_____ _____

Signature of Patient or Guardian Date

_____

Print name of Patient