

## Patient Information

Patient Name: \_\_\_\_\_  
 If under 18, Parent/Legal Guardian Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone 1: \_\_\_\_\_ (home/cell/work) Phone 2: \_\_\_\_\_ (home/cell/work)  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Email: \_\_\_\_\_ I do **NOT** want to receive exclusive offers via email. \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Emergency Contact Phone#(s): \_\_\_\_\_

How did you learn about our practice?

Referring Provider and Practice \_\_\_\_\_ Phone #: \_\_\_\_\_

**\*Do you want DLC to send your medical records to your Referring Provider above? Please circle YES NO**

- Patient/Friend
- Internet
- Community Event \_\_\_\_\_
- Other \_\_\_\_\_

Primary Care Physician and Practice (PCP): \_\_\_\_\_ Phone# \_\_\_\_\_

**\*Do you want DLC to send your medical records to your PCP above? Please circle YES NO**

Pharmacy: \_\_\_\_\_ Address/Phone#: \_\_\_\_\_

**INSURANCE:** Please provide a copy of your insurance card. DLC accepts BCBS, Cigna, Medicare, United Healthcare. *We are out of network with Blue Local, Blue Value and Medicare Advantage Plans.* Patients are responsible for paying Out-of-Network service, knowing their own insurance benefits and securing referral obligations.

Does your insurance require a referral from your PCP? Please indicate: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Primary Insured Person: \_\_\_\_\_ Secondary Insured Person: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

<b>Current Medications and Supplements</b>			
Medication	Dosage	Frequency	Route
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any **allergies to medications**? If yes, please list:

\_\_\_\_\_

No Allergies to Medications

**Skin Disease History:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acne                      | <input type="checkbox"/> Melanoma                   | <input type="checkbox"/> Tanning bed use |
| <input type="checkbox"/> Actinic keratosis         | <input type="checkbox"/> Peeling/blistering sunburn | <input type="checkbox"/> Warts           |
| <input type="checkbox"/> Atypical/dysplastic moles | <input type="checkbox"/> Psoriasis                  | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Basal cell skin cancer    | <input type="checkbox"/> Rosacea                    |  |
| <input type="checkbox"/> Cold sores                | <input type="checkbox"/> Seasonal allergies         |  |
| <input type="checkbox"/> Dry skin                  | <input type="checkbox"/> Squamous cell carcinoma    |  |
| <input type="checkbox"/> Eczema                    |   |  |

<p><b>Sunscreen use:</b></p> <input type="checkbox"/> Yes, SPF _____ <input type="checkbox"/> No
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**Medical History:**

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> HIV/AIDS       | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Defibrillator       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Radiation treatment  |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Depression          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver disease  | <input type="checkbox"/> Rheumatoid arthritis |
|  | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> MRSA           | <input type="checkbox"/> Stroke               |
|  |  |  | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Thyroid disorder     |
|  |  |  |   | <input type="checkbox"/> Tuberculosis         |

**Surgical History:**

Year	Body Location	Type of Procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Tobacco use:**

- Never Smoked  
 Quit/Former Smoker  
 Current Daily Smoker  
(Packs per day): \_\_\_\_\_

<p><b>Please indicate:</b></p> <input type="checkbox"/> Allergy to bandages, tape or adhesive <input type="checkbox"/> Allergy to lidocaine <input type="checkbox"/> Pregnant or nursing <input type="checkbox"/> Currently taking a blood thinner
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**Family Skin Disease History:**

- \_\_ Melanoma. Family Member (s): \_\_\_\_\_  
 \_\_ Basal Cell Carcinoma. Family Member(s): \_\_\_\_\_  
 \_\_ Squamous Cell Carcinoma. Family Member (s): \_\_\_\_\_  
 \_\_ Autoimmune Disease. Family Member (s): \_\_\_\_\_

**Do you currently have any of the following symptoms?**

- |   |   |
|---|---|
| <input type="checkbox"/> Chills                 | <input type="checkbox"/> Rash                   |
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Problems with bleeding |
| <input type="checkbox"/> Problems with scarring | <input type="checkbox"/> Easy bruising          |
| <input type="checkbox"/> Problems with healing  |   |

## Financial Policy and Office Protocols

**Insurance Participation:** Medicare, Cigna, United Healthcare and Blue Cross Blue Shield\*: At the time of service, we collect copay, co-insurance and/or deductible amounts. We also collect payment in full for non-covered services. You are responsible for charges your insurance company does not pay. ***\*We do not accept Blue Local, Blue Value or Medicare Advantage Plans.***

**Third Party Charges:** Your care may require our providers to send a specimen or blood work to an outside laboratory for testing. The outside lab will bill your insurance company directly. You will receive a separate bill from the labs: TriPoint Diagnostics, DermPath and/or Labcorp.

**Out-of-Network and Self-Pay Patients:** Payment is due in full at the time of service. We accept cash, check, Visa, MasterCard, Discover, and American Express. There is a \$30.00 Returned Check fee. Please keep your receipt and obtain instructions from our office for how to file an out of network claim. Your insurance company will send the explanation of benefits and any payment directly to you. It is your responsibility to follow up with your insurance carrier. **The cosmetic consultation fee is \$105.00.**

**Appointments:** You will receive a text reminder 3 days prior to your appointment. We require a 48-hour cancellation notice. **A \$105.00 fee will be charged for cancelled appointments with less than a 48- hour notice unless for an emergency.**

- For the first office visit, please arrive 15-20 minutes early. New patient forms must be completed prior to seeing the medical provider and receiving any medical care. New Patient Forms are also available on our website, [www.dlcofchapelhill.com](http://www.dlcofchapelhill.com) under the toolbar tab “Resources” and the dropdown menu “Forms and Insurance”. Then select “Patient forms and financial policy” to download the forms.
- Each time a patient misses an appointment without providing 48-hours notification (“no shows”), another patient is prevented from receiving care. After two no-show appointments, we will collect \$105.00 in advance to schedule future appointments. If an individual has three (3) no shows within a three (3) year period, we may discharge the individual from our practice.
- Please be aware that Monday appointments must be cancelled by noon on the previous Friday. If you are scheduled for Accutane follow-up, and you cancel or “no show,” we may not be able to reschedule your appointment in a timely manner.
- Anytime you will be late for an appointment, please call to inform us. If running more than 15 minutes late, you may be required to reschedule. We will try to accommodate, as we all run late sometimes.
- Appointment length is determined by the health issues provided to the front office at the time the appointment is scheduled (i.e. is the visit for acne, a mole check, a surgical procedure, or a consultation regarding specific skin and/or cosmetic concerns?). Lengthy delays result in patients asking for additional time to address issues other than those originally scheduled. Please be considerate of those waiting.

**Medication Refills:** Please allow up to 48 hours for prescription requests. Whenever possible, we try to accommodate requests the same day you call. Please submit your request via the patient portal, as this can result in a quicker response time. You may also leave a voicemail on the office **NURSE** line to request a refill. Please leave your **full name, DOB, name of medication and pharmacy contact information.** Please note: Patients not seen at our office in at least one year will be required to schedule an appointment before we will refill the prescription.

**Lab and Test Results:** Some test and lab results can take up to 10-14 days. We will call you if your results require further treatment or evaluation. Your normal results will be available on the patient portal. You may request a copy of your records.

**Medical Records:** Medical records require a 72-hour notice and are subject to a fee. A medical records release form must be on file before records are released. Records may be released to another provider free of charge. Your records may be released to you free of charge.

**Referrals:** You are responsible for insurance prior authorizations. You will need to know if a referral is needed from your insurance company for your visit. If your DLC provider wants to refer you for a test, or to another specialist, please allow 5 days for the medical staff to process your referral.

**No Recording Policy:** DLC prohibits the use of any recording devices in the waiting area or in the exam rooms. Any unauthorized recording or photography may result in dismissal from our practice.

**Responsibilities:** As our patient, it is your responsibility to: truthfully complete all required chart forms; arrive for your appointment on time and prepared; follow the prescribed treatment plan; have dependable transportation to and from our office; have adult supervision post-procedure when required by our providers; accept financial responsibility for any charges not covered by your insurance and pay for services at the time rendered; treat our staff and other patients respectfully.

I agree that I have completed all information truthfully and have read and understand my patient responsibilities.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if not self): \_\_\_\_\_

## Privacy Notice Agreement

I understand that the Dermatology & Laser Center of Chapel Hill, PLLC, may use my health information for treatment, payment, and health care operations. I have been shown a copy of the practice's Notice of Privacy Practices (NPP) that describes how my information may be used and disclosed. I understand that the Practice has the right to change this notice at any time. I may obtain a current copy of the NPP by contacting the practice at (919) 942-2922.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if not self): \_\_\_\_\_