

Grafton Dermatology.

DISEASES OF THE SKIN, HAIR AND NAILS.



microdermabrasion

medical facials

tattoo removal

laser resurfacing

laser hair removal

spider veins

body sculpting

skin cancer removal

PATIENT INFORMATION

Name of Patient: _____ Today's Date ___/___/___
Last First M.I.
Mailing Address _____
Street City State Zip
Home Phone _____
Area Code SS#
Date of Birth ___/___/___ Age ___ Sex ___ Marital Status _____
Place of Employment _____ Work Phone _____

Parent of Responsible Party (if different from patient)

Name of Patient: _____ Today's Date ___/___/___
Last First M.I.
Mailing Address _____
City State Zip
Home Phone _____
Area Code SS#
Date of Birth ___/___/___ Age ___ Sex ___ Marital Status _____
Place of Employment _____ Work Phone _____

Insurance Information (Please present insurance card at time of check in)

Primary Insurance Name _____ Secondary Insurance Name _____
Name of Insured _____ Name of Insured _____
SS# _____ Date of Birth _____ SS# _____ Date of Birth _____
Group # _____ Group # _____
Employer Name _____ Employer Name _____
Employer Phone # _____ Employer Phone # _____
Area Code Area Code
Relationship to Patient _____ Relationship to Patient _____

In case of Emergency, who should be notified? _____ Phone _____
Pharmacy of choice _____ Phone _____
Referred by: _____ Primary Care Physician _____
How did you hear about our office: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits, for which I am entitled.

I will not hold Grafton Dermatology responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date

Authorization I authorize the release of medical information to my primary care or referring physician, to consultants if and needed as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Patient or Responsible Party Signature _____

Financial responsibilities for patients receiving treatment at Grafton Dermatology & Cosmetic Surgery In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit cards. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductibles, non-covered services and copayments. In the event you account must be turned over to collections, you will be responsible for any additional charges. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature

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MEDICAL HISTORY

Date _____

Name of Patient: _____ Date of Birth ___/___/___

Reason for visit _____

Are you allergic to any medication? No Yes "if yes, list:"

List medications you are currently taking:

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

Lungs	Yes	No	Other Systemic	Yes	No
Bronchitis	Yes	No	Diabetes	Yes	No
Emphysema	Yes	No	Thyroid	Yes	No
Asthma	Yes	No	Kidney	Yes	No
Chronic Cough	Yes	No	Bladder	Yes	No
Morning Cough	Yes	No	Stomach	Yes	No

Vascular

High Blood Pressure	Yes	No
Chest Pain	Yes	No
Heart Attack	Yes	No
Heart Murmur	Yes	No
Irregular Heart Beat	Yes	No
Pace Maker	Yes	No
Phlebitis	Yes	No

Bowel

Hepatitis	Yes	No
Glaucoma	Yes	No
Arthritis	Yes	No
Convulsions	Yes	No
Epilepsy	Yes	No
Seizures	Yes	No
Fainting	Yes	No

Do you drink alcohol No Yes "If yes, drinks per day _____"

Do you use IV drugs No Yes "If yes, what _____"

Have you had or have you ever been exposed to HIV (AIDS) No Yes

Have you ever had dental anesthesia (Novacaine) No Yes

Any bad reaction? No Yes

Skin

"When you are exposed to the sun, do you?"	Tan	Tan and burn	Burn
Have you ever had skin cancer?	No	Yes	
Has any one in your family had skin cancer?	No	Yes	
Do you have a history of any skin diseases?	No	Yes	

"If yes, Please list: _____"

List any other disease or condition we should know about: _____

List any surgeries you have had: _____

Please answer the following questions:

Do you smoke? No Yes "If yes, how much _____"

Do you bleed easily? No Yes

(Women) Are you pregnant? No Yes Due Date: _____

Do you have artificial joint(s)? No Yes

What is your occupation _____

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HOUMA

MORGAN CITY

THIBODAUX

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Date _____

Name of Patient: _____

Date of Birth __/__/__

Please list below a person or persons (other than your self) to whom we can disclose your medical information:

When calling your home, can we leave a message for you? Yes No

Can we call a cell phone number? Yes No

If yes, Please give the number _____

Can we call your place of employment? Yes No

If Yes, Please give phone number _____

Would you like our office to call and remind you of any future appointments? Yes No

Please list any special contact instructions:

Patient Signature

Date

If you need further assistance please call our office at 985.876.5000 or email us at info@graftonderm.com.