APDerm®
ADVANCED DERMATOLOGY
OF MELROSE

Name

First *Last* *M.I.*

Marital Status:
□ Single □ Married
□ Separated □ Partnered
□ Divorced □ Widowed

Preferred Pronouns:
□ He/Him
□ She/Her
□ They/Them

Sex Assigned at Birth
□ M □ F

Legal Sex: Same as sex assigned at birth?
□ Yes □ No

DOB _____/_____/_____
MM *DD* *YYYY*

Sexual Orientation: (Optional)
□ Lesbian, gay, or homosexual
□ Straight or heterosexual □ Bisexual
□ Something else, please describe_____
□ Don't know □ Choose not to disclose

Gender Identity: (Optional)
□ Identifies as Male □ Transgender Male □ Identifies as Female
□ Transgender Female □ Gender Non-conforming
□ Choose not to disclose □ Other _____

Race:
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or Other Pacific Islander
□ White □ Other Race_____

Ethnicity:
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown
□ Decline

Language:
□ English □ Spanish
□ French □ Russian
□ Portuguese □ Chinese
□ Other _____

Address

Street *City* *State* *Zip*

Cell Phone

Consent to Text □ Yes □ No

Home Phone

Work Phone

Email

Employer

Occupation

Spouse's Name

Primary Care Physician

Name *Phone Number*

Preferred Pharmacy

Name *Street* *City* *State* *ZIP*

Emergency Contact

Name *Relation to Patient* *Phone Number*

Current Medications		Allergies
Medication Name	*Dose*	**Allergies**
Medication Name	*Dose*	**Allergies**
Medication Name	*Dose*	**Allergies**

Skin

Do you have any of the following?

- ☐ Abnormal/Changing Moles
- ☐ Acne
- ☐ Boils
- ☐ Bleed Easily
- ☐ Cold Sores
- ☐ Dry/Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Non-healing Sores
- ☐ Psoriasis
- ☐ Rash
- ☐ Rosacea
- ☐ Scars
- ☐ Warts
- ☐ Other _____

Details

When you are exposed to the sun do you:
☐ Tan Only ☐ Tan and burn ☐ Burn Only

Have you ever used a tanning booth? ☐ Yes ☐ No
If yes, do you currently? ☐ Yes ☐ No

Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SPF?

Have you ever had skin cancer?
☐ Yes ☐ No ☐ Don't Know

If yes, what type(s), where, and when?

Type(s) *Location(s)* *Year(s)*

Type(s) *Location(s)* *Year(s)*

Personal Medical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bowel Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infectious Disease
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis

Lifestyle Factors

Smoking Tobacco Status

- ☐ Current Everyday Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoked

Smokeless Tobacco Status

- ☐ Current User
- ☐ Former User
- ☐ Never Used

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much per week?

Details

Women Only

Are you currently pregnant? ☐ Yes ☐ No
If yes, how many weeks?

Are you trying to get pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No

Surgical History

Surgery *Date*

Surgery *Date*

Surgery *Date*

Surgery *Date*

Surgery *Date*

Surgery *Date*

Surgery *Date*

Family History

Has anyone in your family ever had any of the following?

If yes, who?

- ☐ Abnormal Moles _____
- ☐ Acne _____
- ☐ Asthma _____
- ☐ Basal Cell Carcinoma _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Eczema _____
- ☐ Hair Loss _____
- ☐ Melanoma _____
- ☐ Psoriasis _____
- ☐ Skin Cancer _____
- ☐ Squamous Cell Carcinoma _____

I consent to receive text messages or emails regarding schedule updates, offers, and events. I know I can opt out at any time by calling the office. I understand Advanced Dermatology of Melrose reserves the right to charge a fee for any scheduled visits that are cancelled with less than 24 hours' notice or are missed without notice (no show).

_____ _____
Signature of Patient (or Guardian if Minor) Date

Consent to Treatment

Initial: ____ I authorize and request care by an Advanced Dermatology and Aesthetic Center physician, physician assistant, and/or nurse practitioner (Provider) and their care team. My Provider will recommend the necessary care to treat my condition. This care may include medical, surgical, or diagnostic treatment such as laboratory tests. Recommended care will not be performed until the treatment or service is explained to me and I consent. I understand I may choose another provider at any time to deliver care or to render a second opinion. I understand my care team may include medical students and other clinical trainees. I am aware that I have the option to decline a trainee's involvement in my care at any time by notifying the practice staff or Provider.

Notice of Privacy Practices

Initial: ____ I acknowledge the receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how my protected health information may be used and disclosed by Advanced Dermatology and Aesthetic Center. I understand that Advanced Dermatology and Aesthetic Center may change its privacy practices at any time. I also understand that the current version of the Notice of Privacy Practices is available on the Advanced Dermatology and Aesthetic Center's website, https://www.apderm.com/notice-of-privacy-practices-apderm/, at each office, or upon my request.

Advanced Dermatology and Aesthetic Center Affiliated Practices

- Adult & Pediatric Dermatology, PC
- Advanced Dermatology and Aesthetic Center
- Associates In Dermatology
- Boston Center For Plastic Surgery
- Boston Dermatology & Laser Center
- Coastal Dermatology
- Dermatology Associates,
- Dermatology Professionals
- DermCare Physicians & Surgeons
- Lexington-Waltham Dermatology Group
- Marla C. Angermeier, MD
- Mystic Valley Dermatology Associates
- Stuart J. Arbesfeld, MD

Cancellation & No-Show Policy

Initial: ____ As a courtesy to our providers and other patients, if you need to cancel or reschedule your appointment, we ask that you notify us at least 48 hours in advance and 72 hours in advance for cosmetic appointments for 60 minutes or longer. *No-Show* appointments are considered appointments that are canceled the same day as the appointment, not showing for an appointment, or when a patient arrives 15 minutes after their scheduled appointment time. A *Late Cancellation* is considered less than 72 hours prior to a 60-minute cosmetic appointment. We reserve the right to charge a non-refundable cancellation or no-show fee of $50-$100 for a general dermatology appointment. If a scheduling fee is required when scheduling a cosmetic appointment, that fee is forfeited if a patient is considered a no-show or has given a late cancellation notice. Three no-show appointments within a 12-month period will put you in jeopardy of scheduling with the clinician and possible dismissal from the practice.

Financial & Office Policies

If you have questions about our financial policy or about paying your bill, please contact our billing department at 978-371-7010, press 5. We accept cash, check, Visa, MasterCard, American Express, and Discover.

Insurance: We participate in most insurance plans. At each visit we verify your current insurance. If we are unable to verify insurance coverage, you will be expected to pay at the time of service. It is your responsibility to know your benefits. Please contact your insurance company directly with any questions you may have regarding your coverage.

Co-Payments and Deductibles: Co-payment and co-insurance are determined by your insurance. All co-payments must be paid at the time of service. A deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay.

Referrals: If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to obtain one. If the referral is not sent to us prior to your appointment, you will be responsible for the cost of services rendered.

Non-Covered Services: Some services you receive may not be covered by your insurance. If you and your provider agree that non-covered services are needed or if you request a non-covered service, you will be responsible for full payment of the non-covered service. Aesthetic services are always payable at the time of the visit.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or guardian to their first appointment. To provide treatment to a minor without the presence of a parent or guardian during subsequent visits, a signed consent form must be on file. All copays or monies due are expected to be paid at the time of each service.

Non-Payment and Returned Checks: We understand that temporary financial problems may affect the timely payment of your balance. Please communicate your situation with the billing department so that we can assist you in the management of your account. If your account is 90 days past due, your account will be referred to a collection agency. This agency may report your delinquency to a credit bureau. You also may be dismissed from our practice for non-payment. There will be a $25 charge for checks returned for insufficient funds.

By signing below, I acknowledge I have read, understand, and agree with the above policies and statements, and that all my questions have been answered in a language that I understand.

Print Patient's Name: _____ Date:_____

Patient/Guardian Signature: _____

Relationship to Patient (if signature is not patient): _____

PERMISSION FOR VERBAL COMMUNICATION

Advanced Dermatology and Aesthetic Center recognizes that patients may prefer family members or friends to be involved in their care. For example, a patient may want their spouse or adult child to assist with billing questions, to be informed about appointments on their behalf or to be updated on their health status. This form serves as a record of your wishes. Please complete this form if you would like to allow our healthcare team members to discuss your health information with a specific individual. This document does not permit release of any written health information to the individuals named.

_____ _____

(Print name of patient or place patient label here) (Date of birth)

Please list the individual(s) that you allow us to speak with about your care:

Family or Friend's Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

I acknowledge and understand that:

- *I am allowing Advanced Dermatology and Aesthetic Center* to *share information with the above-named individual(s) only by verbal discussions and that my permission does not give the above-named individual(s) access to my hard-copy or electronic medical record.*
- *The information I allow Advanced Dermatology and Aesthetic Center to share is not limited unless specified:* _____.
- *My permission will remain in effect for an unlimited amount of time unless another date is listed, or I cancel my permission:* _____.
- *I can change my permission at any time by contacting the dermatology office where I receive care, but my cancellation will not have an effect on information shared prior to my cancellation.*
- *Information shared with the above-named individual(s) may be further shared by them and not protected under confidentiality and privacy laws.*
- *My permission is voluntary, and Advanced Dermatology and Aesthetic Center may not condition my treatment, payment, or eligibility for services on my signature.*
- *If at any time I do not want my healthcare team members to discuss my healthcare information with the above-named individual(s), I must provide written notice to the dermatology office where I receive care or contact the privacy officer at (978) 849-7582 or 526 Main Street, Suite 302, Acton, Massachusetts 01720.*

By signing below, I acknowledge I have read, understand, and agree with the information on this form and that all my questions have been answered in a language that I understand.

Patient/Guardian Signature:_____Date: _____

Representative's Name: _____Relationship to Patient: _____