History & Intake Form

Name: _____ Date of Birth: _____

Preferred Name: _____ Occupation: _____

What are you here for today?_____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Removed (Right, Left)
Bladder Removed	Kidney Stone Removal
Mastectomy (Right, Left, Bilateral)	Kidney Transplant
Lumpectomy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Cyst
Breast Reduction	Ovaries Removed: Ovarian Cancer
Breast Implants	Prostate Removed: Prostate Cancer
Colectomy: Colon Cancer Resection	Prostate Biopsy
Colectomy: Diverticulitis	TURP
Colectomy: IBD	Skin Biopsy
Gallbladder Removed	Basal Cell Cancer Surgery
Coronary Artery Bypass	Squamous Cell Carcinoma Surgery
PTCA	Melanoma Surgery
Mechanical Valve Replacement	Spleen Removed
Biological Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Heart Transplant	Hysterectomy: Fibroids
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement, Hip (Right, Left, Bilateral)	None
Joint Replacement within last 2 years	Other: _____
Kidney Biopsy	

Female Patient: (please circle)

Pregnant Breast Feeding

Skin Disease History: (please circle all that apply)

Acne	Eczema	Precancerous Moles
Actinic Keratoses	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	
Dry Skin	Other: _____	

Do you wear Sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

Any other family history: _____ ____

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

Pharmacy: (name and phone number)

_____

Height: _____ **Weight:** _____

Social History: (Please circle all that apply)

Cigarette Smoking:
Never smoked | Quit: former smoker | Smokes daily | Smokes less than daily

Alcohol Use:
Alcohol: none | Alcohol: 1-2 drinks a day | Alcohol: 3 or more drinks a day

Flu Vaccine: (Please circle whether you had the vaccine this season)

Yes No

Patient Intake Form

First Name:_____ Middle Initial: _____ Last Name: _____

Street Address:_____ Apt/Unit #:_____

City:_____ State:_____ Zip Code: _____

Email Address:_____

SSN:_____ DOB: _____

Cell Phone #:_____ Alternate Phone #: _____

Gender: Male / Female (circle one) Marital Status: _____

Employment Status: (circle one) Full-Time Part-Time Student

Employer/School: _____

Emergency Contact (Name and #): _____

Primary Care Physician:_____

Referring Physician:_____

Where did you hear about Riva?

___ Friend ___ Newspaper Ad ___ Billboard ___ Facebook ___ Charlotte Today ___ Website

___ Magazine ___ Email Campaign ___ Event ___ Radio ___ Reviews ___ Other: _____

___ Medical Referral - Doctor's Name:_____

****Primary Insurance Information****

Insurance Name: _____

Policy Holder:_____ Relationship to Holder: _____

Policy Holder DOB:_____ Policy Holder SSN: _____

Insurance Holder Address: _____

****Secondary Insurance Information****

Insurance Name: _____

Policy Holder:_____ Relationship to Holder: _____

Policy Holder DOB:_____ Policy Holder SSN: _____

Payment Policy

Payment in full is expected at the time of service. This includes any deductibles and/or co-pays applicable to your policy. If you are covered by one of our contracted insurance companies, we will file the claim for you. Please see The Office Manager before your visit I special payment arrangements are necessary.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. I have read all the information on these registration forms and certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the information above.

Signature:_____ Date: _____

Parent/Guardian(If under 18): _____ Date:_____

I hereby authorize Riva Aesthetic Dermatology, PLLC to furnish information to insurance carriers concerning my diagnosis and treatments and I request payment of medical insurance benefits to either myself or the party who accepts assignment. I understand that this authorization will remain in effect for as long as my dependent or I remain a patient.

Signature:_____ Date: _____

Scheduled Appointments

We understand that delays can happen, however we do not wish to inconvenience our other patients when trying to accommodate late arrivals. **If a patient arrives more than 15 minutes past their scheduled time, they may be asked to reschedule the appointment.**

Cancellation/ No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from being seen. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule when you would like to be seen. **If your appointment is not cancelled at least 24 hours in advance you will be charged a thirty five dollar ($35) fee: this will not be covered by your insurance company.**

Cancellation/ No Show Policy for Procedures

If it becomes necessary to reschedule your procedure, please call our office as soon as possible so that the space may be used by another patient. If you fail to cancel your appointment at least 24 hours in advance, there will be a $50 fee for a 30 minutes or shorter procedures, and a $100 fee for longer procedures. Thank you for calling in advance.

Signature:_____ Date: _____

Parent/Guardian (If under 18): _____ Date: _____

COMMUNICATION & ACKNOWLEDGMENT FORM

Patient's name (Please print): _____ Date of Birth:_____

Riva Aesthetic Dermatology is not permitted, by law, to provide medical information to anyone other than the patient except for treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

The staff at Riva Aesthetic Dermatology would like to know with whom, if anyone, you want us to be able to discuss your treatment, treatment plans, condition updates, lab results, appointment information, billing information, or picking up of samples. This would also include leaving messages on your answering machine or in your voicemail box. If you would also like us to communicate with you by e-mail to address your health information or for specials, promotions, or other office events, please indicate so below.

Please complete the following so that the individuals you specify can have access to your information as described above.

I, _____, as a patient of Riva Aesthetic Dermatology, authorize the release of my medical information regarding my treatment and care to the following individuals upon their request:

_____	_____	_____	_____
Name *(please print)*	Date of Birth	Relationship	Phone Number
_____	_____	_____	_____
Name *(please print)*	Date of Birth	Relationship	Phone Number

_____ _____

Signature of Patient / Authorized Representative Date

E-mail: I, _____, authorize Riva Aesthetic Dermatology to e-mail me information regarding my care or for specials, promotions, or other office events that may become available. I understand that my e-mail address will be kept confidential in the same manner as all my other health related information.

(E-mail address at which I wish to be contacted): _____

By signing below, I authorize Riva Aesthetic Dermatology to communicate protected health information to me as described above. I further acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for Riva Aesthetic Dermatology describing how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I may obtain a complete copy of the Notice for my records upon request at any time. My consent will remain in effect as long as I am a patient of Riva Aesthetic Dermatology unless and until I notify Riva Aesthetic Dermatology in writing of any changes.

Please Print Name:_____ Date: _____

Signature of Patient/ Authorized Representative: _____

Relationship to Patient (If person other than patient signing this form): _____

For Office Use Only: Reason Patient unable/unwilling to sign:_____ (rev. 7/18)