SKIN & VEIN CENTER
DERMATOLOGY · COSMETIC SURGERY · DERMSPA

PATIENT REGISTRATION & MEDICAL HISTORY

PATIENT INFORMATION

Name_____SSN_____Date_____
Last First M

Birthdate_____ Gender: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Address 1_____ Apt/Suite_____City_____State_____Zip_____

Phone (check preferred contact number): Home [ ]_____Cell [ ]_____Work [ ]_____

Do you agree to opt-in for text messaging Yes □ No

Email_____May we send information to you at this email address □ Yes □ No

We promise never to share, trade, sell, or market your email address

Employer_____Occupation _____

Referring Physician [ ] PCP or [ ] Other Physician Name_____Phone_____

If not referred, how did you hear about us? [ ] Website [ ] Current Patient [ ] Internet [ ] E-Newsletter [ ] Other_____

Pharmacy_____Address_____

Our practice utilizes e-prescribing. Prescriptions are sent electronically to the pharmacy of your choice for safety and convenience

*** Required: PRIMARY INS:_____ SECONDARY INS:_____**

DO YOU HAVE MEDICARE PART B or MEDICARE REPLACEMENT? YES OR NO

IF YES, NAME OF CARRIER_____

GUARANTOR (PARTY RESPONSIBLE FOR PAYMENT) If Guarantor is patient, check here ✓ and skip to next section

Last Name:_____First:_____SSN_____

Address_____ City_____State_____Zip_____

Home Phone_____Work Phone_____ Sex:_____Date of Birth:_____/_____/_____

Relationship to Patient: [ ] Spouse [ ] Parent [ ] Legal Guardian

EMERGENCY CONTACT: Name:_____Phone_____Relationship_____

PREVIOUS HOSPITALIZATIONS (place, reason, and dates)

Location Reason Dates

_____

_____

_____

PAYMENT REQUIRED AT TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original.

Signature_____Date_____

Relationship (please circle one): PATIENT SPOUSE PARENT GUARDIAN

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Patient Name:_____ SSN_____ACCT #_____

REASONS FOR TODAY'S VISIT: _____

Smoking Status (check one) [ ]Never been a smoker [ ]Former smoker [ ]Current sometimes smoker [ ]Current everyday smoker

These questions are included to comply with new Federal Health guidelines - we are required to ask for this information.	Ethnicity (check one)	[ ] Hispanic or Latino	[ ] Not Hispanic or Latino	[ ] Declined or Unspecified
	Race (check one)	[ ]American Indian/Alaskan Native [ ] Black/African American	[ ] Asian [ ] White	[ ] Native Hawaiian/Other Pacific Island [ ] Declined or Unspecified
	Preferred Language (check one)	[ ] English	[ ] Spanish	[ ] Declined or Unspecified

MEDICATIONS (please list all prescriptions & over-the-counter medication)
If you currently do not take any medications, check this box ☐
_____ How long?_____
_____ How long?_____
_____ How long?_____

MEDICATION ALLERGIES (please specify medication & reactions)
Medication Reaction
_____ _____
_____ _____
_____ _____

REVIEW OF SYSTEMS Please check ☑ Yes ☑ No - Do you have any of the following:

[ ] No[ ] Yes	Asthma/Breathing Problems	[ ] No[ ] Yes	Hay Fever/Seasonal Allergies	[ ] No[ ] Yes	History of TB or Exposure
[ ] No[ ] Yes	Persistent Cough/Lung Conditions	[ ] No[ ] Yes	History of Heart Attacks	[ ] No[ ] Yes	High Blood Pressure
[ ] No[ ] Yes	Night Sweats	[ ] No[ ] Yes	Depression	[ ] No[ ] Yes	Seizures
[ ] No[ ] Yes	Hallucinations	[ ] No[ ] Yes	Headaches/Migraines	[ ] No[ ] Yes	Vision Changes
[ ] No[ ] Yes	Blind Spots	[ ] No[ ] Yes	Nose Bleeds	[ ] No[ ] Yes	Ringing in Ears
[ ] No[ ] Yes	Persistent Sore Throat or Toothaches	[ ] No[ ] Yes	History of Hepatitis	[ ] No[ ] Yes	Arthritis
[ ] No[ ] Yes	Extended Muscle Pain or Weakness	[ ] No[ ] Yes	Painful Urination	[ ] No[ ] Yes	Diabetes
[ ] No[ ] Yes	Thyroid	[ ] No[ ] Yes	Sensitivity to Cold	[ ] No[ ] Yes	History of Eczema
[ ] No[ ] Yes	History of Psoriasis	[ ] No[ ] Yes	History of Blood Transfusions	[ ] No[ ] Yes	Anemia
[ ] No[ ] Yes	History of IV Drug Abuse	[ ] No[ ] Yes	Excessive Sweating	[ ] No[ ] Yes	Heat or Cold Intolerance
[ ] No[ ] Yes	Blood in Stool	[ ] No[ ] Yes	Abdominal Pain	[ ] No[ ] Yes	Sudden Weight Loss or Gain

[ ] No[ ] Yes Cancer, if yes, what type?_____
[ ] No[ ] Yes Any family history of skin cancer or other cancer? If yes, please describe:_____
[ ] No[ ] Yes Have you ever been tested for HIV? If yes, what were your results? ☐ Positive ☐ Negative

FOR VEIN PATIENTS ONLY:
New Patients do NOT initial this Box below

Family history of phlebitis?	[ ] No[ ] Yes	Do you have abnormal periods?	[ ] No[ ] Yes
History of blood clots/clotting problems?	[ ] No[ ] Yes	Do you have excessive body hair?	[ ] No[ ] Yes
Family history of blood clots/clotting problems?	[ ] No[ ] Yes	Could you be pregnant?	[ ] No[ ] Yes
History of pulmonary embolism?	[ ] No[ ] Yes	Are you currently breastfeeding?	[ ] No[ ] Yes
History of phlebitis?	[ ] No[ ] Yes	Family history of varicose veins?	[ ] No[ ] Yes

FOR FEMALE PATIENTS:

Yearly Review With No Changes
(initial below)
Initial_____ Date_____
Initial_____ Date_____

CURRENT MEDICAL CONDITIONS (check ☑ all applicable)

Reactions or allergies to local anesthetics? (such as those used by the dentist)	[ ] No	[ ] Yes
Bleeding disorders, easy bruising or bleeding longer than most people when cut?	[ ] No	[ ] Yes
Have you ever fainted?	[ ] No	[ ] Yes
Do cuts on your skin heal with raised scars?	[ ] No	[ ] Yes
Are you allergic or have you had a 'bad reaction' to any substances applied to your skin?	[ ] No	[ ] Yes
Allergies to Latex? (gloves)	[ ] No	[ ] Yes
Have you had previous cosmetic surgery?	[ ] No	[ ] Yes

If yes, please list_____

Welcome to the Skin & Vein Center 6/2025

Our team is committed to providing you with the highest quality care. Please review the following important information.

New Patient Policy
All patients must complete information forms and present a valid state-issued ID before being seen. If you have not been seen in the past 3 years or have only received cosmetic treatments, you are considered a new dermatology patient. **You have the right to refuse treatment.**

Insurance & Participation
All of our providers are in the same insurance networks. You are responsible for checking if we are in-network with your insurance plan. In Michigan, if you agree to receive non-emergency care from an out-of-network provider, the protections under the Surprise Billing Act do not apply. If we are out-of-network, we will still only charge in-network rates. ***Initals***____

Patients must provide all current insurance details. Insurance claims submitted past carrier deadlines or without required referrals become the patient's responsibility. If prior authorization is needed for surgery, we will handle that process. Co-pays, deductibles, co-insurances and non-covered services are your responsibility. You must assist us in resolving delayed payments. Non-participating or non-responsive carriers may result in you being billed directly.

Treatment Coverage
All dermatology procedures are classified as **"SURGERY".** Your insurance may have separate deductibles for surgical services. We only bill medically necessary treatments. Since coverage varies widely, please review your policy or request codes to verify coverage before treatment. You are responsible for non-covered services at in-network rates based on our good faith estimate.

Specialized Treatments

- **Acne / Milia**: Often not covered; commonly billed as procedure 10040, diagnosis L700 / L720.
- **Skin Tags / Angiomas / Varicose Veins**: Must be diagnosed first; coverage varies and pre-authorization may be needed.
- **Skin Exams**: Full-body exams are billed as office visits, not wellness visits.

Minor Patients
The accompanying parent/guardian is financially responsible. A written consent is required for minors attending future visits alone. A parent/guardian must be present for any biopsy / surgical procedure or change in diagnosis.

Financial Policy
Payment is due at the time of service. We accept cash, checks, major credit cards, and Care Credit**. Products are non-returnable.**

- **Cosmetic Packages**: Valid for 1 year. Broken packages are charged at single procedure pricing.
- **Cosmetic Consults**: Free unless a dermatology issue is addressed, in which case insurance will be billed.

Returned Checks & Collections
Returned checks incur a $25 fee. Balances over 60 days may be subject to a 30% collection fee and forwarded to collections.

Authorization
By signing below, you acknowledge and agree to this financial policy, authorize the release of medical information for insurance purposes, and direct payment of benefits to the provider.

_____	_____	_____	___/___/___
Signature of Patient/Guardian	Printed Name	Relationship to Patient	Date

PRIVACY NOTICE ACKNOWLEDGEMENT:

I have been offered or received a copy of the Skin & Vein Centers Notice of Privacy Practices.

_____	_____	_____	___/___/___
Signature of Patient/Guardian	Printed Name	Relationship to Patient	Date

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Consent for Dermatologic Treatment

At Skin & Vein Centers, we are committed to providing you with high-quality care. Before treatment, your provider will discuss your condition and the recommended procedures to ensure you are fully informed and able to make the best decision. ***You have the right to refuse treatment.***

Common Conditions Treated: Examples include: Acne, Skin Tags (Acrochordons), Angiomas, Warts, Eczema, Psoriasis, Contact Dermatitis, Molluscum, Alopecia, Actinic Keratosis, and more.

Treatment Methods:

1. **Shave / Excision** – Lesion removal, may be sent to lab for diagnosis.
2. **Destruction** – Liquid nitrogen / chemical used to destroy the lesion.
3. **Injection / Dermajet** – Steroid medication injected or delivered needle-free.
4. **Photodynamic Therapy (PDT)** – Light-sensitive medication and light treatment.

Important Considerations:

- Multiple treatments and methods may be needed.
- Results are not guaranteed; lesions may recur or new ones may develop.
- Scarring or blistering may occur
- Contact our office if you notice signs of infection (redness, pus, increasing pain).

Cosmetic / Non Covered Procedures:

If treated for skin tags, angiomas, telangiectasias, or milia:

- A billable office visit is required for diagnosis.
- Cosmetic removal (not covered by insurance): $50 for 1–10 lesions $100 for 11–20 lesions $5 each additional over 20

Alopecia: Treatment may be considered cosmetic by your insurance. Please review your policy for exclusions.

Lesion Removal & Insurance:

- Only “medically necessary” removals are submitted to insurance.
- Patient responsibility may apply (deductible, co-pay, co-insurance).
- Procedures may be subject to surgical deductible.
- Your plan may exclude coverage even for medically necessary treatment.
- Non-covered/cosmetic procedures will be billed per our Good Faith Estimate (available upon request).
- Payment is due at time of service for self-pay or cosmetic cases.

Lab Fees: Removed lesions are sent to an independent lab.

- Billing questions regarding lab services should be directed to the lab (Dermatopathology Laboratory of Central States-DLCS)

Consent Duration:
This consent is valid for one year. After one year, a new consent must be signed if treatment continues.

Patient Signature / Parent / Guardian: _____ **Date:** _____