PRESTIGE DERMATOLOGY

Dr. Natalie L. Monticciolo
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PLEASE FILL OUT COMPLETELY, SIGN WHERE INDICATED, PLEASE PRINT

PATIENT information: Date _____

Name _____ Parent / Guardian Name _____

Address _____ City _____ State _____ Zip _____

Home Ph _____ Work Ph _____ Cell Ph _____ Employer _____

D.O.B. ____/____/_____ Age ____ Sex _____ SS # (required) _____-_____-_____ Occupation _____

Martial Status (circle one) Single Married Divorced

Spouse's Name _____ Occupation _____ Work Phone _____

RESPONSIBLE PARTY: (Insured)

Name _____ D.O.B. ____/____/_____ SS# _____-_____-_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Relationship to Patient _____

NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name _____ Home Phone _____

Address _____ Work Phone _____

REFERRAL INFORMATION: (Please check the appropriate box below to help us determine how you were referred to our office)

☐ Physician ☐ Friend ☐ Relative ☐ One of our Patient ☐ Billboard

☐ Advertising ☐ The Yellow Pages ☐ Internet ☐ Insurance ☐ Other

Primary Care Physician _____ Phone _____

FINANCIAL RESPONSIBILITY:

- I understand that all co-payments, deductibles, and past due balances are due at the time of the visit. If I am uninsured, I understand that the payment is due at the time of the visit. I have verified participation of the provider with the insurance company.
- I understand that if my insurance coverage has expired or lapsed, I will be responsible for payment. If my insurance company denies payment or does not pay within 35 days as required by the state law, I am responsible for payment.
- In the case of returned checks, the fee charged by the bank will be added to my account. In the case of nonpayment for services performed, 10% interest will be added to my account from the date of service.
- All collection costs incurred by Prestige Dermatology for outstanding balances will be added to my account. I understand that I am financially responsible for cosmetic, non-covered or medically non-indicated services.
- I hereby authorize the physicians/providers of Prestige Dermatology to provide medical treatment to myself/child. I authorize payment of medical benefits to physician or supplier or supplier for these service and all future claims.

X _____Date_____/_____/_____
Signed (Patient or Parent/Guardian)

Are there any area(s) of concern on your skin that you would like us to address today:

_____

_____

_____

Please list all medications that you take including vitamins and herbal supplements.

_____

_____

_____

Please list allergies to any medication.

_____

_____

Please circle all that pertain to you.

Mitral valve prolapse	**Asthma**	**Hepatitis**
Artificial Valve	**Shortness of breath**	**HIV**
Heart Attack	**Allergies**	**Liver disease**
High Blood Pressure	**Hay Fever**	**Tuberculosis**
Low Blood Pressure	**Epilepsy**	**Anemia**
Swollen Ankles	**Congestive Heart Failure**	**Rheumatic**
High Cholesterol	**Angina**	**Stroke**
Chest pain	**Blood transfusion**	**Diabetes**
Cancer other than skin	**Skin cancer**	**Smoke**
Drink alcohol	**Pregnant**	**Nursing**
Take birth control pills		

Health issues and procedures or products of interest to you (please circle all that apply).

Botox	**Skin Care Advice**
Chemical Peels	**Liver spots / Age Spots**
Juvederm or Restylane	**Sunscreen Advice**
Skin Rejuvenation	**Removing Facial Blood Vessels**
Retin-A-products	**Hair Removal**
Acne	**Other (please specify) _____**