CATHERINE M. DIGIORGIO, MD
DERMATOLOGY · LASER · AESTHETICS

Patient Intake & History Form

Name:_____ Date of Birth:_____

Preferred Name/Nickname: _____ Sex: M / F Preferred Pronoun:_____ Occupation:_____

Address:_____City:_____State:____Zip:_____

Email Address:_____ Referred by:_____

Mobile Phone #:(____)_____Home Phone #: (___)_____Work Phone#:(___)_____

OK to leave messages: YES / NO Preferred method of contact: Email / Call / Text Preferred Language: _____

Emergency Contact: _____ Relationship:_____ Phone: (___)_____

Pharmacy

Pharmacy Name: _____

Phone number: _____

Street/City/Zip:_____

Primary Care Physician

Name: _____

Address: _____

City/Zip/Phone:_____

Past Medical History: (Select any of the following medical conditions you have/have had)

☐ Anxiety	☐ Autoimmune Disease	☐ Pacemaker/Defibrillator	☐ Cold sores (herpes)
☐ Asthma	☐ Heart Disease	☐ Stroke	☐ Psoriasis
☐ Cancer	☐ High Blood Pressure	☐ Seizures	☐ Vitiligo
☐ Diabetes	☐ Bleeding Disorder	☐ Immunocompromised	☐ Migraines
☐ Hepatitis	☐ Radiation Treatment	☐ HIV/AIDS	☐ **NONE**

☐ Other:_____

Do you have a personal history of skin cancer? Yes / No If yes, please list:_____
Do you have a family history of melanoma? Yes / No If yes, Family member:_____
Do you wear sunscreen? Yes / No
Have you ever taken GOLD as an oral medication? YES / NO
Have you ever taken Accutane? YES / NO If yes, date of last dose _____

Currently pregnant? YES / NO Planning pregnancy? YES / NO Currently breastfeeding? YES / NO

Past Surgical History: (please list your surgical history): ☐ **NONE**

_____

_____

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Medications:(Please list prescription and over the counter) ☐ **NONE**	**Allergies:** (Please list) ☐ **NONE**
_____	_____
_____	_____
_____	_____
_____	_____

By submitting these forms, you give us permission to link all Surescripts, which is an online database that gives us access to your medications.

Social History:

Tobacco use: Current smoker / Quit: Former / Less than daily / Never
Alcohol Use: Less than 1 drink a day / 1-2 drinks a day / 3 or more drinks per day / None
Illicit Drug Use: Yes / No If yes, please describe_____

ALERTS (please select if any of the following):

☐ Allergy to adhesive
☐ Allergy to lidocaine
☐ Allergy to Latex
☐ Allergy to topical antibiotics
☐ Taking Blood thinners
☐ Artificial joints (within past 2 years)
☐ Artificial heart valve

Notice of Privacy Practices

A Notice of Privacy Practices has been provided to me by Dermatology, Laser & Aesthetics, PLLC d/b/a CMD Dermatology, Laser & Aesthetics. (A copy is available at the front desk for your convenience).

By signing this form, I confirm that the above information is accurate and I acknowledge that a Notice of Privacy Practices has been provided to me.

_____ _____
Signature Date

Name of person filling this form if not patient: _____

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Financial Agreement:

Dermatology, Laser & Aesthetics, PLLC d/b/a CMD Dermatology, Laser & Aesthetics ("Practice") is committed to providing the highest quality of care to our patients. The following is a statement of our financial policy, which we require you to read and sign. **All payments are due at the time of your visit.** The Practice accepts Visa, American Express and Mastercard.

FINANCIAL RESPONSIBILITY: The Practice does not accept commercial insurance of any kind. None of your services, whether medical or cosmetic, will be processed through your insurance. It is your responsibility to submit any claims for reimbursement directly to your insurance and the Practice cannot guarantee that any services will be reimbursed by your insurance.

COLLECTIONS/CC ON FILE: Payment is due at the time services are rendered. In the event of default, I understand that my account will be forwarded to a collection agency. You understand that the patient/debtor assumes all costs of collection, including but not limited to, collection personnel fees, court costs, interest, and legal fees. Interest in the amount of one percent (1%) will accrue on all accounts over ninety (90) days past due. The Practice may withhold future services until the balance is paid in full.

COSMETIC SERVICES: Cosmetic services are not covered by insurance. Your payment is due at the time services are rendered.

PATHOLOGY/LAB SERVICES: Based on the services rendered during a visit, you may receive an additional bill from the Practice's third-party lab service provider. You will be notified of this prior to any procedure that may incur such fee. The Practice is unable to adjust these charges as they are provided by a third-party vendor.

PRODUCT/SERVICES: There is no guarantee that a product or service will satisfy all of your needs. There are absolutely NO REFUNDS for products or services rendered.

CANCELLATIONS/NO SHOWS: It is the goal of the Practice to provide you with exceptional, personalized care in a timely fashion. Accordingly, the Practice will not double book appointment slots. The Practice will block your appointment to allow you to have the highest quality, individualized time. You understand that a "no-show" fee or late cancellation fee of One Hundred Fifty Dollars (**150$)** will be charged for any appointment not cancelled/rescheduled at least twenty-four (24) hours before your appointment time.

I understand that I may be charged a One Hundred Fifty Dollars (**$150) deposit to schedule an appointment. If I cancel or reschedule an appointment with less than twenty-four (24) hours' notice or No Show an appointment, I will lose the deposit.**

I understand that for any scheduled procedures (e.g., laser, surgery, liposuction, devices, etc) there will be a non-refundable deposit required and if I reschedule within less than 3 business days or NO SHOW, I will lose the deposit.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY, I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH ABOVE.

Signature:_____Date:_____

Printed Name:_____