SkinMD®
AESTHETIC AND MEDICAL SKIN CARE

804 NE Mall Blvd
Hurst, TX 76053
817-595-4500
817-595-4505 Fax

750 Eureka St
Weatherford, TX 76086
817-550-6073
817-550-6076 Fax

Thank you for choosing SkinMD for your skin care needs. Please take a few minutes to answer the following questions so that we can better assist you with your health care needs.

PATIENT DEMOGRAPHICS

Name (first, middle initial, last)			
Address	City	State	Zip code
SSN	Date of Birth	Marital Status	
Gender (circle one) Male Female	Email		
Preferred phone #		Circle one HOME MOBILE WORK	
Second Phone # (required)		Circle one HOME MOBILE WORK OTHER	
May we leave a detailed message? **YES** **NO**	You will receive appointment reminders by text. May we text you regarding specials and events? **YES** **NO**	Would you like to receive cosmetic specials via email? **YES** **NO**	
Race	Ethnicity	Primary Language	

EMERGENCY CONTACT

Name	Relationship	Phone #

RELEASE OF MEDICAL INFORMATION

I, the patient/legal guardian, do hereby authorize SkinMD to use or disclose my health information as outlined in the **PRIVACY NOTICE** that has been provided to me. I have received, read and understand the information detailed.

I hereby give permission to disclose, discuss and speak with the individuals listed below regarding my personal health information or treatment. I understand that unless specifically listed below, SkinMD cannot speak to **ANY** individual concerning my medical or financial information including, but not limited to appointments, test results, prescriptions, school or work releases. This includes my spouse, children, siblings, or parent (if I am 18 years or older). I understand that I can amend this list at any time by submitting a request in writing. I consent to the release of my health information to the following individuals:

Name	Phone	Relationship	Medical information	Financial Information
			YES NO	YES NO
			YES NO	YES NO

Signed: _____ Date: _____

(Patient or legal guardian if under 18)

OTHER		
How did you hear about us?	PCP name	Referring Physician
Employer	Occupation	Work Phone #
Preferred Pharmacy	Pharmacy phone #	Pharmacy Address

PRIMARY INSURANCE PLAN		
Subscriber Name	Relationship to Patient	Subscriber DOB
Subscriber SSN	Employer	Employer Phone #
Employer Address		
Insurance Plan Name	Group #	Policy #
Insurance Company Address		Insurance Phone #

SECONDARY INSURANCE PLAN		
Subscriber Name	Relationship to Patient	Subscriber DOB
Subscriber SSN	Employer	Employer Phone #
Employer Address		
Insurance Plan Name	Group #	Policy #
Insurance Company Address		Insurance Phone #

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my own account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I am responsible for notifying SkinMD of any changes in my health status or the above information.

ASSIGNMENTS OF BENEFITS: I hereby assign all medical and surgical benefits, to which I'm entitled, including Medicare, private insurance and any other health plans to Tracie, D. Swayden, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original. I understand that I am financially responsible for all the charges, whether or not paid by insurance. I hereby authorize assignee to release all information necessary to secure payment. I understand there is a fee of $50 for a returned check.

I understand that if I have a surgical procedure or biopsy performed, there are two charges (1) a charge by SkinMD for collecting the biopsy; and (2) a charge to examine the specimen by a dermatopathologist (ProPath Laboratory) to do the reading. I understand I will be billed separately for this reading.

I understand that my insurance company, and/or Medicare/supplemental policy may have a preferred lab for blood work. It is my responsibility to know which preferred lab I can use.

I understand that there is a non-refundable fee for not showing to my appointment or canceling within 24 hours. The medical fee is $50; cosmetic is $100; Surgery is $200; and Coolsculpt or Sculptra is my 50% deposit as extensive arrangements are required to provide these appointments

Signed: _____ Date: _____

(Patient or legal guardian if under 18)

Briefly describe the reason for your visit today _____
Would you like a mole check today? YES NO

SKIN DISEASE HISTORY - have you ever had any of the following? **Please circle below or choose: NONE**

Skin Cancers	Abscess/Boil	Hay fever/allergies	Poison Ivy/Oak
Basal Cell	Actinic Keratosis	Hives	Psoriasis
Squamous Cell	Blistering sunburns	Itchy/flaky scalp	Scarring
Melanoma	Cold Sores	Non-healing Wounds	Wart
Acne	Dry skin/eczema	Precancerous Moles	

MEDICAL HISTORY - have you had any of the following? **Please circle below or choose: NONE**

Artificial Joints	Defibrillator	HIV/AIDS	Pacemaker
Asthma	Depression	Infections	Radiation/Chemo
Autoimmune Disease	Diabetes	Kidney Disease	Stomach Problems
Bleeding Disorders	Heart disease	Liver Disease	Stroke
Blood Thinners	Hepatitis	MRSA	Thyroid Disease
Cancer	High Blood Pressure	Other	Tuberculosis

PAST SURGERIES - have you had any of the following? **Please circle below or choose: NONE**

Abdominal	ENT	Implants	Organ Transplant
Accidents	Eye	Joint replacement	Spine
Cancer	Female	Mole Surgery	
Cosmetic	Fractures	None	

SOCIAL HISTORY

Do you currently or previously?

Smoke Drink Alcohol Use Drugs Foreign Travel Used Tanning Beds Use Sunscreen

When was your last Flu Shot? _____ Shingles Shot? _____

FAMILY HISTORY **Please circle below or choose :NONE**

Skin Cancer	Adopted	Cancer	High Blood Pressure
Basal	Allergies	Cardiac Disease	Metabolic Disease
Squamous	Autoimmune	Diabetes	Skin Disease
Melanoma	Bleeding Disorder	Genetic/Inherited	Unknown

REVIEW OF SYSTEMS Circle any symptoms you have **TODAY** as it relates to this visit:

Fever	Vision changes	Nausea	Depression
Fatigue	Chest pain	Vomiting	Anxiety
Weight loss	Palpitations	Diarrhea	Bruising
Headaches	Cough	Joint pain	Swollen nodes
Frequent infections	Shortness of Breath	Numbness	

FEMALES – Circle any that may apply

Breast Feeding Currently Pregnant Trying to get pregnant Infertile Hormone Replacement Post Menopausal

PATIENT NAME: _____ DATE: _____

MEDICATIONS - list **ALL** prescription, non-prescriptions, over the counter, herbal, as needed

☐ I do not take any of the above

NAME	DOSAGE	FREQUENCY	REASON TAKING

ALLERGIES

☐ I have no known allergies

NAME	REACTION

PATIENT NAME: _____ DATE: _____

PHARMACY NAME:_____ PHONE NUMBER:_____

PRIMARY CARE PHYSICIAN:_____ PHONE NUMBER:_____

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Tracie D. Swayden, M.D.
www.skinmdonline.com

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Credit / Debit Card Authorization

SkinMD is streamlining our financial practices. All patients will be asked to provide a credit/debit card at the time of check-in. Any and all information related to your credit card, is held securely and available to process at the time of check-out. Please know that any credit card number provided may be changed at any time.

Once insurance payments have been received by SkinMD, your credit card will be charged any remaining balance due and you will be mailed a copy of the receipt for your records.

This will be an advantage for you; as you will not have to write out a check and mail it in. It will also be an advantage for us, SkinMD, as it will decrease the amount of statements that that we must generate and send out. This combination will benefit all parties in helping keep the cost of healthcare down.

If your balance remaining is more than $200 we will call you before charging the card on file.

Should there be any questions, please do not hesitate to ask. We are here to help you!

I, _____ authorize SkinMD to charge outstanding balances on my account to the following credit card:

Visa MasterCard Discover American Express Other: _____

Account / Card Number: _____ Exp Date: _____

Name on Card (print): _____

Patient Name (print): _____ DOB: _____

____ *Initial here if you would like to be notified of ANY amount owed prior to automatic billing.*

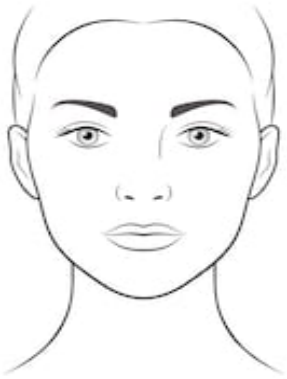
Signature: _____ Date: _____

Patient Name:_____

If you are not already scheduled for a cosmetic consultation, please request one today!

COSMETIC QUESTIONNAIRE

Healthy skin is in! Here at SKINMD our goal is to help you achieve the healthy, beautiful skin you have always desired. We have numerous non-invasive, affordable procedures and products that we can customize to help you achieve your skin goals!



Please document your top 3 concerns and services you are interested in:

1.) _____

_____

2.) _____

_____

3.) _____

_____

How does your skin typically react in the sun?

___ Always Burns, Never tans
___ Burns easily, Tans minimally
___ Sometimes burns, Usually tans
___ Rarely burns, Tans dark
___ Minimally burns, Tans easily
___ Never burns, Tans very dark

Have you previously had any of the following cosmetic procedures?

Botox/ Dysport
Fillers:
Belotero/ Juvederm/ Restylane/ Sculptra
CoolSculpt/ SureSculpt
Kybella
Skin Tightening/ Radio Frequency
Microdermabrasion
Chemical Peels
Skin Pen
Hydrafacial
IPL/ Photofacial
Laser Hair Removal
Cellulite Laser
Fraxel/ Resurfacing
Other: _____

What is your current Skin Care regimen? (Please star products you feel have made an impact on your skin.)

Wash: _____
Toner: _____
Exfoliator: _____
Moisturizer: _____
Growth Factor/
Stem Cell: _____
Lightener: _____
Anti-oxidant _____
Sunscreen: _____
Other: _____
Retinol/ Retin-A: _____