RETURN PATIENTS: PLEASE ENTER ONLY INFORMATION WHICH HAS CHANGED SINCE YOUR LAST VISIT.

☐ **NONE OF THE INFORMATION BELOW HAS CHANGED SINCE MY LAST VISIT.**

PATIENT

NAME: ______________________ **DATE:** ______________

ADDRESS: ______________________ (STREET) ______________ (CITY) ______ (STATE) ________ (ZIP)

SEX: ________ **AGE:** ________ **DATE OF BIRTH:** _____ /_____ / _______

TELEPHONE: HOME: (   ) - ________ - ________ WORK: (   ) - ________ - ________ CELL: (   ) - ________ - ________

E-MAIL ADDRESS: ______________________ **OCCUPATION / POSITION:** ______________________

BUSINESS NAME: ______________________

BUSINESS ADDRESS ______________________ (STREET) ______________ (CITY) ______ (STATE) ________ (ZIP)

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED / WIDOWER ☐ SEPARATED

SPOUSE INFORMATION: NAME: ______________________ OCCUPATION: ______________ TEL: (   ) - ______ - ______

RESPONSIBLE PARTY

INSURED'S NAME: ______________________ **RELATIONSHIP TO PATIENT:** ______________ **TEL**: (   ) - ______ - ______

SEX: ________ **DATE OF BIRTH:** _____ /_____ / _______

INSURED'S ADDRESS: ______________________ (STREET) ______________ (CITY) ______ (STATE) ________ (ZIP)

INSURANCE INFORMATION (ONLY FILL OUT IF ASKED TO)

NAME OF INSURANCE COMPANY: ______________________

ID #: ______________________ **GROUP #:** ______________ **POLICY #:** ______________

REFERRED BY: ______________________

PRIMARY MEDICAL DOCTOR: ______________________

PRIVACY: I HAVE RECEIVED A COPY OF THE NSCMA NOTICE OF PRIVACY PRACTICES REGARDING PRIVACY OF MY MEDICAL RECORDS AND MEDICAL INFORMATION.

____
SIGNATURE

PLEASE RETURN THIS COMPLETED FORM TO THE RECEPTIONIST. ALSO, PLEASE ATTACH YOUR INSURANCE CARD TO THE TOP OF THE CLIPBOARD. IT WILL BE RETURNED TO YOU AT OR BEFORE THE TIME OF CHECKOUT.

NORTH SHORE CENTER FOR MEDICAL AESTHETICS, LTD.
DR. ANDREW SCHEMAN ● DR. TODD JOHNSON ● DR. SHERYL HOYER
ERIC KING, PA-C ● ELIZABETH COOK, PA-C
NORTHBROOK COURT PROFESSIONAL PLAZA ● 1535 LAKE COOK ROAD ● SUITE 401
NORTHBROOK, ILLINOIS 60062 ● TEL: (847) 480-1111 ● FAX: (847) 480-1131

History Intake Form

Patient Name: ____ **Date of Birth:** ____________________

Patient Medical History: Have you ever had any of the following:

Seasonal Allergies	Yes	No	Glaucoma	Yes	No	High Blood Pressure	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	Pacemaker	Yes	No
Hay Fever	Yes	No	HIV/AIDS	Yes	No	Diabetes	Yes	No
						Tobacco Use	Yes	No

Patient Dermatologic History: Have you ever had any of the following:

Eczema	Yes	No	Melanoma	Yes	No
Childhood Eczema	Yes	No	Other Skin Cancer	Yes	No
Hives	Yes	No	Psoriasis	Yes	No
Keloids	Yes	No	Sun Burn (excessive)	Yes	No

Currently breastfeeding or pregnant? Yes No

Height _____ft _____in

Weight ______lbs

Family History: Has any blood relative ever had any of the following:

Seasonal Allergies	Yes	No	Eczema	Yes	No	Malignant Melanoma	Yes	No
Hives	Yes	No	Psoriasis	Yes	No	Other Skin Cancer	Yes	No
Asthma	Yes	No	Hay Fever	Yes	No	Acne	Yes	No

List any drug allergies: ____

Review of Systems: Do you have any current medical problems in the following areas

Allergies	Yes	No	Endocrine/Hormonal	Yes	No	Hematologic (bleeding)	Yes	No
Cardiovascular	Yes	No	Eyes	Yes	No	Lungs	Yes	No
Chills/Fever/Headache	Yes	No	Gastrointestinal	Yes	No	Musculoskeletal	Yes	No
Ear/Nose/Throat	Yes	No	Genital/Urinary	Yes	No	Neurologic/Psychiatric	Yes	No

If yes; name of condition: ____

Previous Skin Cancer surgery: ___________________**Any previous MAJOR surgeries:** _______________________

Skin Type (circle one)

(I) Always Burns; Never tans

(II) Can tan a little but gets red first

(III) Tans easily but can burn if gets too much sun

(IV) Tans easily. Doesn't burn usually

(V) Dark Caucasian or light African American

(VI) Dark African American

Medications/ Supplements	Dosage	Directions	Medications/ Supplements	Dosage	Directions

Topical Medications (creams, etc.)	Directions	Topical Medications (creams, etc.)	Directions

X_______________________________________ ____________________ __________________

Signature of the patient or guardian Date Provider Initials

North Shore Center for Medical Aesthetics, Ltd.; Fees and Payment Policies

Fees; Thank you for choosing North Shore Center for Medical Aesthetics, Ltd. (NSCMA) as your dermatology provider. We always strive to treat you with courtesy and to provide the finest medical care. Changes in health care laws have made it essential to collect full payment for all services in a timely manner in order to continue to provide the quality of care you have come to expect from us.

Payments due at time of service; Payment of copays are required at time of service prior to your appointment. All services not covered by insurance are also due at time of service. In addition, amounts due for deductibles and copayments in which the amount due can be determined are also due at time of service. We accept credit cards, debit cards, checks or cash. For credit card payments, we charge a 4% credit card transaction fee.

Other payments; You will be required to provide a credit card number which we will store electronically encrypted to be used for forgotten payments, missed appointments and any amount your insurance company indicates is your responsibility on your explanation of benefits. You authorize NSCMA and our billing service (Physician Billing Solutions) to charge this credit card for these amounts if >30 days past due plus a 4% credit card transaction fee. You will receive a receipt for all payments.

Cancellation policy; A cancellation fee will be charged for cancellations with less than 48 hour notice for surgery, less than 24 hour notice for other appointments and for missed appointments. For patch testing, there is a $350 cancellation fee which will be charged unless patch testing is cancelled at least 1 week prior to testing. The cancellation fee will not be covered by insurance and you authorize us to bill your credit card or this fee unless an alternative, prompt means of payment is made.

Past Due Balances; For amounts less than 90 days past due, you may contact out billing office to determine if you qualify for Care Credit or other payments options to pay for past due amounts which are a hardship. If you have a balance due which is over 90 days past due, you will receive a notice giving you 30 days to pay the past due amount or to find care at another dermatology practice. If payment is not received during this 30 day period, you will not be able to receive care from our doctors until payment has been made. Amounts greater than 60 days past due may be subject to a late payment fee.

Insurance; Insurance claims will be submitted to your insurance as a courtesy, however, you are fully responsible for all amounts due which are not paid by your insurance. If we are not a provider in your insurance plan or if you do not have a referral which is required by your insurance, you will be responsible for full payment of all charges at the time of service.

I authorize NSCMA to provide dermatological services and agree to abide by the above policies.

Signature; ____ Date; ________________________

Name on Credit Card: ____

Zip Code: _________________

Credit Card No: ____

Expiration Date: _________________________________ CVV Code: _____________