WELCOME TO THE OFFICE OF HEATHER J. ROBERTS, M.D., AMC

Our goal is to provide our patients with personalized expert skin care that meets and exceeds expectations.
Please fill out these forms completely. The better we communicate, the better we can care for you.

Today's Date: _____ Referred By: _____

Name: _____ _____ _____
(Last) *(First)* *(Middle Initial)*

Birth Date: _____ ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Pharmacy Name/Phone #: _____

E-Mail Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address if different than above: _____

City: _____ State: _____ Zip Code: _____

Drivers License #: _____ Social Security #: _____

Employer Name: _____ Occupation: _____

Address: _____

Spouse/Guardian Name&Address: _____

Employer Phone#: _____ Occupation: _____

Emergency Contact: _____ _____ _____
(Name) *(Relationship)* *(Phone Number)*

Address: _____ _____ _____ _____
(Street) *(City)* *(State)* *(Zip)*

Other family members who are current patients (relationship): _____

_____

TO RESPECT YOUR PRIVACY, PLEASE CHECK OFF THE PREFERRED NUMBERS AND/OR EMAIL WE SHOULD USE TO LEAVE DETAILED PRIVATE INFORMATION FOR:

Appointment Reminders ☐ Home ☐ Work ☐ Cell Phone ☐ Email ☐ Other _____

Lab/Biopsy Results ☐ Home ☐ Work ☐ Cell Phone ☐ Email ☐ Other _____

Skin Cancer Screening Reminders ☐ Email ☐ US Postal

May we contact you regarding upcoming promotions, new products, services or procedures by e-mail? ☐ Yes ☐ No

HEATHER J. ROBERTS,M.D., AMC

HEALTH QUESTIONNAIRE

Name: _____ **Age:** _____ **Date:** _____

HISTORY OF PAST ILLNESS: Have you had the following?

Skin Cancer ☐ Yes ☐ No Type: ☐ Basal ☐ Squamous ☐ Melanoma

Location: _____

Any Serious Illness ☐ Yes ☐ No Major Childhood Disease ☐ Yes ☐ No

If YES to any of the above, please describe in detail: _____

_____

Have you had any major surgery? ☐ Yes ☐ No Describe(Type and Date): _____

_____

MEDICATIONS:

Prescriptions: _____

Over-The-Counter (including vitamin&herbs): _____

Skin Care Products currently using: _____

ALLERGIES: (Drugs, Chemicals, Food) _____

FAMILY HISTORY: (Check the following medical conditions that have occurred in your family)

Disease	Mother	Father	Other Relative	Disease	Mother	Father	Other Relative
Psoriasis	☐	☐	☐	Severe Acne	☐	☐	☐
Asthma	☐	☐	☐	Skin Cancer-Non Melanoma	☐	☐	☐
Hay Fever	☐	☐	☐	Malignant Melanoma	☐	☐	☐
Eczema	☐	☐	☐	Cancer	☐	☐	☐

ANY OTHER SKIN CONDITIONS THAT RUN IN YOUR FAMILY? ☐ Yes ☐ No

If yes, please explain _____

SOCIAL HISTORY:

Alcoholic Beverages: ☐ Yes ☐ No Tobacco: ☐ Yes ☐ Former ☐ No

GENERAL REVIEW:

Have you been in good health all your life? ☐ Yes ☐ No Recent Weight Changes? ☐ Yes ☐ No Gain/Loss ____

SKIN:

Sensitive Skin (gets red or irritated)	☐ Yes	☐ No	History of shingles	☐ Yes	☐ No
Acne	☐ Yes	☐ No	Warts	☐ Yes	☐ No
History of scars or keloids	☐ Yes	☐ No	Difficulty in healing of wounds	☐ Yes	☐ No
Hair or nail changes	☐ Yes	☐ No	Hives, eczema or itching	☐ Yes	☐ No
Any bleeding tendency (i.e. easy bruising)	☐ Yes	☐ No	Abnormal pigmentation or loss of pigment	☐ Yes	☐ No
Sun exposure in past	☐ Yes	☐ No	Flushing	☐ Yes	☐ No
Blistering sunburns (in childhood/teens)	☐ Yes	☐ No			

HEALTH QUESTIONARE CONTINUED (HEATHER J. ROBERTS,M.D., AMC)

Name: _____ Date: _____

HEAD, EYES, NOSE AND THROAT:

Cold Sores ☐ Yes ☐ No
Chronic Sinus Trouble ☐ Yes ☐ No
Hay Fever ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Plastic Surgery ☐ Yes ☐ No
If Yes, type: _____

CARDIOVASCULAR (Heart&Blood Vessels):

Heart Trouble or Heart Attacks ☐ Yes ☐ No
Do you require Antibiotics for dental work ☐ Yes ☐ No
High Blood Pressure (Hypertention) ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Implantable Device ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No

RESPIRATORY (Lungs):

Asthma or Wheezing ☐ Yes ☐ No

GASTROINTESTINAL(Intestinal Tract&Liver):

Liver Trouble, Cirrhosis or Hepatitis ☐ Yes ☐ No
Stomach Ulcers ☐ Yes ☐ No

GYNECOLOGICAL:

Date of your last period _____
Birth Control pills or Hormone therapy ☐ Yes ☐ No
Number of Pregnancies _____
Are you currently pregnant ☐ Yes ☐ No
Date of your last Pap smear _____
Recurrent yeast infections ☐ Yes ☐ No
Name of Birth Control pill _____
Number of children _____ Ages _____
History of abnormal pap ☐ Yes ☐ No

SEXUAL HISTORY:

Venereal Disease, Genital Sores/Discharge or Herpes ☐ Yes ☐ No

EXTREMITIES & JOINTS:

Varicose Veins (swollen veins in legs) ☐ Yes ☐ No
Phlebitis or Blood Clots in veins ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No

ENDOCRINE(Glands);

Thyroid Disease or Goiter ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Excessive Hair Growth ☐ Yes ☐ No
Excessive Underarm Sweating ☐ Yes ☐ No

BLOOD/LYMPHATIC:

Blood Disease, Anemia or Transfusions ☐ Yes ☐ No
Immune Disorders (HIV or AIDS) ☐ Yes ☐ No

PSYCHIATRIC:

Depression ☐ Yes ☐ No
Anxiety Attacks ☐ Yes ☐ No

**Signature of Patient/Responsible party* _____ (Required)

Date: _____

**If completing on line, please refer to the "digital signature" policy listed above.*

Heather J. Roberts, MD, AMC

Financial and Insurance Claim Submission Policy

Our office is not contracted with any insurance companies or Medicare. Full payment for all services rendered is expected at the time of your visit. As a courtesy, we submit your claims for all medical visits and medically necessary procedures directly to your insurance company for reimbursement to you.

If at anytime you have questions or concerns regarding the cost of a procedure, insurance submissions or claim denials, our staff is here to assist you.

Please note you will be reimbursed by your insurance under "out of network" benefits and in accordance with your plan's allowables and deductibles. As each insurance plan has their own "rules" we cannot predict how much your plan will pay. If you want to contact your insurance company before any procedures or appointments in our office, we can give you the billing codes in advance (if we know what is being treated) so you can get an idea on the reimbursement.

In order submit a claim to your insurance company, we need current insurance information including the billing address and ID numbers with updates any time this information changes.

RELEASE OF RECORDS: I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case to process any past, present, and/or future claims. I understand this authorization can be withdrawn upon my request at any time.

For your convenience in paying, this office will accept your ATM/Debit card, Master Card, Visa, American Express and cash. For identity protection, we will need a copy of your driver's license at your first visit.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AND INSURANCE CLAIM SUBMISSION POLICY AND AGREE TO ITS TERMS REGARDLESS OF MY INSURANCE STATUS.

I KNOW THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

I certify that the information that I have provided is true and correct to the best of my knowledge. I will notify the office of Heather J. Roberts, M.D., AMC of any changes in my personal contact information.

I have read and agree to the above.

Patient Signature_____ Date_____

Witness Signature _____ Date_____

Heather J. Roberts, MD, AMC

Cancellation Policy – *Effective 06/01/2017*

As a small private dermatology office dedicated to the highest quality, personalized and detailed care, we try our best to accommodate patients in a timely manner when scheduling.

While we understand schedule conflicts arise that prevent patients from keeping appointments, we kindly request you cancel with at least 24 hours prior notification. Patients who cancel without 24 hour notice (last minute cancellation) or who simply do not show up (no show) for appointments cause significant challenges in the office by preventing access to care for patients who really want to be seen. Because we keep an active waiting list for patients, your courtesy in canceling early will allow us to accommodate other patient's scheduling needs too. We appreciate your understanding and consideration in this matter.

Failure to cancel an appointment 24 hours prior to your scheduled time or not showing up for your appointment will result in a $50 fee which must be paid prior to scheduling future visits.

Repeated late cancellation or no show appointments may result in your being discharged from our practice.

SKIN CANCER SCREENING POLICY

Due to the extensive appointment time allocated for skin cancer screening in our office and the active list of patients trying to schedule those exams, our policy is as follows:

1st No Show or last minute cancellation (less than 24 hour notice of appointment) will result in a **$75 fee and will require 50% payment of a non-refundable deposit for your next Skin Cancer Screening**.

2nd No Show or last minute cancellation will result in a **$125 fee and will require 100% payment of a non-refundable deposit for you next Skin Cancer Screening.**

3rd No Show or last minute cancellation will result in a **$250 fee and will require payment in advance to schedule any future skin cancer screenings.**

As a courtesy, we text and/or call all patients 1 - 2 days in advance to remind you of your appointment(s). If you do not respond to your reminder call or message, the cancellation policy will still remain in effect.

No future appointments can be scheduled nor can records be transferred without the payment of the above fees.

I have read and fully understand the above policy and agree to its terms.

Patient Signature_____ Date_____

Witness Signature _____ Date_____