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 know your history, the better we can care for you.

Today's Date: _____ Referred By: _____

PATIENT'S INFORMATION:

Patient's Name: _____ _____ _____
Last *First* *Middle Initial*

Birth Date: _____ ☐ Male ☐ Female Home Phone #: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address if different than above: _____

_____

Pharmacy Name/Phone #: _____

Pediatrician's Name: _____ Phone #: _____

PARENTS' INFORMATION

Mother's Name: _____ Home Phone #: _____

E-Mail Address: _____ Cell Phone #: _____

Social Security #: _____ Driver's License #: _____

Home Address (If different from above): _____

Employer Name: _____

Father's Name: _____ Home Phone #: _____

E-Mail Address: _____ Cell Phone #: _____

Social Security #: _____ Driver's License #: _____

Home Address (if different from above): _____

Employer Name: _____

Nearest friend or relative residing at an address other than your own:

Name: _____ Relationship: _____ Phone #: _____

Address: _____

Other Family Members who are Current Patients: _____

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

Appointment Reminders: ☐ Mom's Home ☐ Mom's Cell ☐ Mom's Email
☐ Dad's Home ☐ Dad's Cell ☐ Dad's Email ☐ Other _____

Lab/Biopsy Results: ☐ Mom's Home ☐ Mom's Cell ☐ Mom's Email
☐ Dad's Home ☐ Dad's Cell ☐ Dad's Email ☐ Other _____

PEDIATRIC HEALTH QUESTIONNAIRE — HEATHER J. ROBERTS, M.D., AMC

Patient Name: _____ Age: _____ Date: _____

HISTORY OF PAST ILLNESS:

Any Serious Illness ☐ Yes ☐ No If yes, please describe _____

HAVE YOU HAD ANY MAJOR SURGERY?

☐ Yes ☐ No Describe (Type and date): _____

ALLERGIES (Drugs, Chemicals, Food): _____

MEDICATIONS:

Prescriptions: _____

Over-the-Counter (Including vitamins&herbs): _____

Skin Care Products currently using: _____

GENERAL REVIEW:

Have you been in good health all your life? ☐ Yes ☐ No

Recent weight change? ☐ Yes ☐ No Gain/Loss ____

SKIN:

Acne	☐ Yes	☐ No
Abnormal pigmentation or loss of pigment	☐ Yes	☐ No
Sensitive skin (gets red or irritated easily)	☐ Yes	☐ No
History of scars or keloids	☐ Yes	☐ No
Hives, eczema or itching	☐ Yes	☐ No
Do you wear sunscreen everyday	☐ Yes	☐ No
Blistering sunburns	☐ Yes	☐ No
Warts	☐ Yes	☐ No

CARDIOVASCULAR (Heart & Blood Vessels):

Heart trouble	☐ Yes	☐ No
Do you require Antibiotics for dental work	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No

Other _____

GYNECOLOGICAL:

Do you get monthly periods	☐ Yes	☐ No
Date of your last period _____		
Birth control pill or hormone therapy	☐ Yes	☐ No
Name of birth control pill _____		

HEAD, EYES, EARS, NOSE OR THROAT:

Herpes Simplex or Cold Sores	☐ Yes	☐ No
Chronic sinus trouble	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No

Other _____

BLOOD/LYMPHATIC:

Blood disease or anemia, transfusions	☐ Yes	☐ No
Immune disorders (HIV or AIDS)	☐ Yes	☐ No
Any bleeding problems	☐ Yes	☐ No

ENDOCRINE (Glands):

Thyroid disease or goiter	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

RESPIRATORY: Asthma or wheezing ☐ Yes ☐ No

PSYCHIATRIC:

Depression	☐ Yes	☐ No
Anxiety attacks	☐ Yes	☐ No

Other _____

SOCIAL HISTORY: Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

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

	Mother	Father	Other Blood Relative		Mother	Father	Other Blood Relative
Asthma	☐	☐	☐	Psoriasis	☐	☐	☐
Hay Fever	☐	☐	☐	Skin Cancer(Non Melanoma)	☐	☐	☐
Eczema	☐	☐	☐	Malignant Melanoma	☐	☐	☐
Severe Acne	☐	☐	☐	Cancer	☐	☐	☐

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

If yes, please explain _____

*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_____