WELCOME TO FREDERICK DERMATOLOGY ASSOCIATES

Thank you for choosing Frederick Dermatology Associates and entrusting your dermatology care to us. We are a full-service dermatology practice with the goal to provide the best dermatological care possible in an atmosphere that takes customer service seriously. We are honored to have you as our patient and will strive to combine the expertise of a university dermatology division with a warm and friendly environment. In our practice we take care of a variety of skin conditions, ranging from acne, moles, and warts, to psoriasis and skin cancer. In addition, we possess expertise in surgical and cosmetic dermatology. If you haven't visited our website, please visit us at www.frederickdermatology.com.

We want your experience at our office to be smooth from the day you make your appointment. In order to make your initial visit pleasant and effortless, please help us by filling out the patient information form that we have included. Additionally, after your appointment, please feel free to provide your feedback through an anonymous survey at www.drscore.com. This way we can listen to your constructive comments and make any necessary changes to achieve the highest level of satisfaction.

We accept patients with all types of insurance and it is our commitment to provide shorter wait times for appointments and better customer service. We have contracted with Medicare, Blue Cross Blue Shield Federal, CareFirst Blue Cross Blue Shield PPO & POS, NCPPO, and InforMed. What this means is that if you do not have one of these insurances, you will be responsible for the cost of the appointment upfront (an average medical appointment ranges for $110-$160 for a new patient and $65-$100 for return patients). Surgical and other procedures may increase the charge for the visit. We will provide you with the forms to obtain reimbursement from your insurance company, which may reimburse you if the policy has an out-of-network option. Payment at the time of the visit may be paid by check or major credit cards. You can also use a flexible spending account or health savings account to pay for your visit.

Again, we are privileged to take care of all your skin care needs. We look forward to seeing you at your appointment. If you have any questions or concerns about our practice, please do not hesitate to contact us.

Kevin Hogan, M.D.

Kathleen Moe, M.D.

& Staff of Frederick Dermatology Associates

45 Thomas Johnson Drive, Suite 209, Frederick, MD 21702 - 301.662.6755

FREDERICK DERMATOLOGY ASSOCIATES, LLC

❑New Patient ❑Name Change ❑Address Change

Today's Date ______/______/______

NAME: Last____________________________________ First______________________________ MI______

Date of Birth: ______/______/______ Social Security ______/____/______ ❑Male ❑ Female

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Partnered

Address: ____

City____________________________________ State________ Zip_______________

Home # (_____) _________________ Work # (_____) _________________ Cell # (_____) _________________

E-Mail ____

Preference of communication: ❑Home ❑Work ❑Cell ❑Email

How did you hear about us? ____

Your Primary Care Provider: ____

PRIMARY INSURANCE

Company____

Policy Holder: ____ DOB: ______/______/______

Relationship to patient: ____

SECONDARY INSURANCE

Company____

Policy Holder: ____ DOB: ______/______/______

Relationship to patient: ____

GUARANTOR (Person responsible for bill) ❑Self or

Name____ Relationship__________________________

DOB________________________________ SS#___________________________________

Address: ____City_____________________________

State_________ Zip_________________ Contact # (______) ___________________________

EMERGENCY CONTACT INFORMATION

In case of Emergency, who should be notified? ____
Phone: (_____) _______________________ Relationship___________________________________

Do you give our office permission to discuss your medical information with family members?

❑YES ❑NO If yes, please provide their name and phone number below.

Name: ____ Phone (_____) _________________________

Name: ____ Phone (_____) _________________________

May we leave personal medical on your voice mail? ❑YES ❑NO
May we e-mail personal medical information to you? ❑YES ❑ NO

Notice of Privacy Practices
A notice of Privacy Practice is available for your review. Please ask the front desk for your copy. My signature below indicates that I have received and/or reviewed a copy of the offices Notices of Uses and Disclosure of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature____ Date_________________

Financial Policy
I agree to pay Frederick Dermatology Associates, LLC for all services deemed not covered by my insurance. I also understand it is my responsibility to verify any "Out-of Network" coverage for insurances that FDA does not participate with. For those insurances that FDA participates with, I agree to pay balances that my insurance indicates are my responsibility. **For those insurances that FDA does NOT participate with, I understand that I am responsible for the balance at the time of service.** If I have a biopsy, I understand that there are two components that will be billed. **1**. Professional component (Pathologist reading.) (*Professional components are billed through FDA*.) **2**. Technical component (Preparation of the specimen). (*Technical components are billed through Dianon/LabCorp*.) I agree to pay for any professional fees related to any pathology services that are not covered by my insurance. I understand that I will be billed for these services at a later date.
I understand that Frederick Dermatology Associates, LLC will provide me with all forms required to submit to my insurance company to facilitate reimbursement if my plan has out-of-network benefits. I understand that Frederick Dermatology Associates, LLC is not responsible for securing my reimbursement from my insurance company.

Cancellation Policy
Frederick Dermatology Associates, LLC requires 24 hour notice when canceling any appointment. I understand that I may be liable for a charge of $40.00 if I fail to give 24 hours notice to cancel an appointment.

Return Check Policy
Frederick Dermatology Associates, LLC charges $35.00 for all returned checks.

I have read and understand the previous statements.

Signature____**Date**_______________

MEDICAL HISTORY FORM

Patient Name: ______________________________________ **DOB:** ________________________

Why are we seeing you today? ____

What is name and location of you preferred pharmacy?____

Medications You Are Currently Taking: *Including Over-The Counter, Vitamins, Herbal & Topical Medications*

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Are you experiencing any of the following symptoms?

- ❑ Fever
- ❑ Chills
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Heat Intolerance
- ❑ Hair Loss/Growth
- ❑ Itching
- ❑ Swollen Lymph Nodes

What is your height: ______________

Weight: ______________

Most recent sun exposure: __________

Date of last menstrual cycle: ____________

Have you taken Accutane before? Y N

Dates:___________________

Please list any allergies and the type of reaction you have:

____

Past Medical History

- ❑ Cold Sores
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Joint Problems
- ❑ Keloid
- ❑ Malignant Lymphoma
- ❑ Malignant Melanoma
- ❑ Pregnancy
- ❑ Basal Cell Carcinoma (Location) __________________
- ❑ Squamous Cell Carcinoma (Location) ________________
- ❑ Non-Melanoma Skin Cancer
- ❑ Scleroderma
- ❑ Systemic Lupus Erythematous
- ❑ **No Significant Past Medical History**

____

Social History

- ❑ History of Blistering Sunburns
- ❑ Non-Smoker
- ❑ No Alcohol Use
- ❑ Alcohol Use Frequency: _________________
- ❑ History of Tanning Salon Use
- ❑ Tobacco Use Pack(s) per day: __________

Family History **Relationship**

- ❑ Asthma ______________________
- ❑ Lupus ______________________
- ❑ Atopic Dermatitis ______________________
- ❑ Psoriasis ______________________
- ❑ Basal Cell Carcinoma ______________________
- ❑ Skin Cancer ____________________
- ❑ Malignant Melanoma ____________________
- ❑ Squamous Cell Carcinoma ____________________
- ❑ No Significant Family History

COSMETIC QUESTIONAIRE

Please check any areas you would like to discuss or receive more information about:

- ❑Freckles / Brown Spots
- ❑Removing Facial Blood Vessels
- ❑Mouth Lines
- ❑Acne
- ❑Leg Spider Veins
- ❑Lower Face Folds
- ❑Sun Damage
- ❑Excessive Hair Growth
- ❑Lip Augmentation
- ❑Excessive Sweating
- ❑Facial Redness
- ❑Large Pores
- ❑Frown Lines
- ❑Rosacea
- ❑Chemical Peels
- ❑Skin Care Regiment
- ❑Wrinkles
- ❑Botox
- ❑Skin Care Products
- ❑Dermal Filler
- ❑Laser Treatments
- ❑Other____________________
____

Have you had any cosmetic surgery or procedures in the past five years? ❑**YES** ❑**NO**

If so, please describe:

____
____
____

Would you like to receive information of any specials or events that we are having? ❑**Yes** ❑**No**

Contact Preference: ❑**Phone** ❑**Mail** ❑**Email** ____

Print Name: ____

Signature: ____