PATIENT REGISTRATION & PAYMENT AGREEMENT

Please give the receptionist your photo I.D. and current insurance card(s)

Reston Dermatology & Cosmetic Center
Syed Amiry, D.O.
1830 Town Center Dr., Suite 410
Reston, VA 20190
(703) 766-2220 / (571) 323-1486 (fax)

Patient Information:

Patient Name:_____ DOB:__/__/____ Age:_____

Patient SSN:____-____-____ Sex: M____F____ Marital Status: M___S___D___W____

Address: _____ City:_____

State:_____ Zip Code:_____ E-Mail Address:_____

Home phone: (___)_____ Work phone: (___)_____ Cell: (___)_____

Employer:_____ Title:_____

Referring Doctor:_____ Phone No: (___)_____

How Did You Hear About Us?_____

Spouse Information:

Spouse Name:_____ DOB:__/__/____ Age:_____

Spouse SSN:____-____-____ Employer:_____ Work phone: (___)_____

Primary Insurance Information:

Insurance Co. Name:_____ Phone No: (___)_____

Address, City, State & Zip Code:_____

Policy ID#:_____ Group #:_____

Subscriber Name:_____ Relationship to Patient:_____

Subscriber DOB:_____ Subscriber SSN:____-____-____

Does your plan require referral?_____ Co-pay Amount: $_____

Secondary Insurance Information:

Secondary Ins. Co, Name:_____ Phone No.: (___)_____

Address, City, State & Zip Code:_____

Policy ID#:_____ Group #:_____

Subscriber Name:_____ Relationship to Patient:_____

Subscriber DOB:_____ Subscriber SSN:____-____-____

Does your plan require referral?_____ Co-pay Amount: $_____

Patient/Guardian Signature: _____ Date: __/__/____

All Appointments Require a Minimum 48-Hour Notice

By signing below, I acknowledge the following:

Cosmetic Missed Appointment Fee (i.e. injectables and aesthetician services) is $150 if I miss a cosmetic appointment without giving prior notice of cancellation.

Laser Appointment Fee is the full laser treatment amount if I miss a laser appointment without giving prior notice of cancellation.

General Dermatology Fee is $25 if I miss a general dermatology appointment without giving prior notice of cancellation.

Surgery Appointment Fee (i.e. Liposuction, Eyelid Surgery, Laser DEKA, and most procedures requiring deposits) is the total deposit if my appointment is not cancelled at least 7 days prior to treatment.

All No-Show Appointments will require a credit card on file if you would like to reschedule your appointment.

Insurance Information

By signing below, I acknowledge the following:

As the patient, it is my responsibility:

- to contact my insurance company to determine whether this office participates with my medical insurance coverage and to inform the office of any changes to my insurance.
- to obtain referrals from my primary care physician for each visit, if required by my insurance.
- to check my insurance plan prior to the office visit and prepare for any and all charges that my insurance company does not cover. This includes deductibles, copays, and other non-covered services. Payment is due at the time of service.
- for appointment fees without insurance, if applicable. Appointment fees without insurance are $125 for the initial visit (not including any treatment or lab work) and $75 for follow up visits (not including any treatment or lab work) due at the time of service.

Parents/guardians are responsible for payments on child accounts.
For your convenience, we accept most major credit cards. We do not accept checks.

By signing below, I authorize:

- insurance payments to go directly to the physician
- release of necessary medical records to the insurance company to process payment.

HIPAA Acknowledgement

By signing below, I acknowledge that I have an opportunity to review, if desired, this practice's "Notice of Privacy Practices."

Please mark which phone numbers we can use to leave messages identifying this practice.

Home____ Cell ____ Work ____

Please mark which phone numbers we can use to leave laboratory/biopsy results or other care issues.

Home____ Cell ____ Work ____

To whom, if anyone, may we disclose laboratory/biopsy results or other care/financial issues:

_____ _____

Name Relationship

I certify that I understand the above information and that the information I have given is correct to the best of my knowledge.

_____ _____

Patient name (print) Patient Signature

_____

Date

Patient Name: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None

Other _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	None

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding? Yes No
Do you require antibiotics prior to a surgical procedure? Yes No
Have you had an artificial joint replacement? Yes No
If yes, when and what body locations? _____
Do you have an artificial heart valve? Yes No
Do you have a pacemaker? Yes No
Do you have a defibrillator? Yes No
Are you pregnant or currently trying to get pregnant? Yes No

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Currently Smoke Has smoked in the Past

Drug Use None

Other : _____

Reston Dermatology & Cosmetic Center
we specialize in enhancing your natural beauty

What are your concerns?

- ☐ Lines and Wrinkles
- ☐ Scarring
- ☐ Excess Fat
- ☐ Varicose Veins / Spider Veins
- ☐ Unwanted Tattoos
- ☐ Saggy Eyelids
- ☐ Saggy Cheeks / Jowls
- ☐ Double Chin
- ☐ Sun Damaged Skin
- ☐ Torn Ear Lobe
- ☐ Brown Discoloration
- ☐ Turkey Neck
- ☐ Excess Sweating
- ☐ Unwanted Hair
- ☐ Brown Spots / Blemishes
- ☐ Facial Redness/Spider Blood Vessels

Would you like to learn about any of the following procedures?

- ☐ Botox®/Dysport
- ☐ Restylane®/Perlane®
- ☐ Radiesse
- ☐ Laser Hair Removal
- ☐ Scar Treatment
- ☐ Mesotherapy
- ☐ Sclerotherapy
- ☐ Liposculputure/ Liposuction
- ☐ Lipoaugmentation
- ☐ Microdermabrasion
- ☐ Laser Tattoo Removal
- ☐ Eyelid Surgery
- ☐ Eyebrow Lift
- ☐ Chemical Facial Rejuvenation (Peels)
- ☐ Aesthetician Services

We also offer cosmetic products at the Reston Dermatology & Cosmetic Center. Please check the product you use or would like to learn more about:

Use	Learn More	
☐	☐	Obagi – For Skin Rejuvenation and Brown Discoloration
☐	☐	Solveré – For Acne
☐	☐	LaRoche Posay and Biomedic Skin Care Products
☐	☐	Neocutis – Lumiere Eye Cream and Blanche Bleaching Cream
☐	☐	Sunscreen – Broad Spectrum for Face and Body