

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 Drive, 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: (____) _____
How did you hear about us? _____
If an existing patient referred you, please write his/her name: _____

Pharmacy Information:

Pharmacy Name: _____ Phone: (____) _____
Pharmacy Address: _____

Spouse Information:

Spouse Name: _____ DOB: ____/____/____ Age: _____
Spouse SSN: _____ - _____ - _____ Employer: _____ Work Phone: (____) _____

Primary Insurance Information:

Insurance Co. Name: _____ Phone: (____) _____
Address, City, State & Zip Code: _____
Policy ID: _____ Group: _____
Subscriber Name: _____ Subscriber DOB: ____/____/____
Subscriber SSN: _____ - _____ - _____ Relationship to Patient: _____
Does your plan require a referral? _____ Copay Amount: \$ _____

Secondary Insurance Information:

Insurance Co. Name: _____ Phone: (____) _____
Address, City, State & Zip Code: _____
Policy ID: _____ Group: _____
Subscriber Name: _____ Subscriber DOB: ____/____/____
Subscriber SSN: _____ - _____ - _____ Relationship to Patient: _____
Does your plan require a referral? _____ Copay 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 up to \$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	Mechanical Valve Replacement	Prostate Removed: Prostate Cancer
Bladder Removed	Biological Valve Replacement	Prostate Biopsy
Mastectomy (Right, Left, Bilateral)	Heart Transplant	TURP
Lumpectomy (Right, Left, Bilateral)	Joint Replacement, Knee (Right, Left, Bilateral)	Skin Biopsy
Breast Biopsy (Right, Left, Bilateral)	Joint Replacement, Hip (Right, Left, Bilateral)	Basal Cell Cancer Surgery
Breast Reduction	Joint Replacement within the last 2 years	Squamous Cell Carcinoma Surgery
Breast Implants	Kidney Biopsy	Melanoma Surgery
Colectomy: Colon Cancer Resection	Kidney Removed (Right, Left)	Spleen Removed
Colectomy: Diverticulitis	Kidney Stone Removal	Testicles Removed (Right, Left, Bilateral)
Colectomy: IBD	Kidney Transplant	Hysterectomy: Fibroids
Gallbladder Removed	Ovaries Removed: Endometriosis	Hysterectomy: Uterine Cancer
Coronary Artery Bypass	Ovaries Removed: Cyst	None
PTCA	Ovaries Removed: Ovarian Cancer	
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 had an adverse reaction to latex or epinephrine?	Yes	No	If yes, describe your reaction: _____
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 location? _____
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	
Are you currently breastfeeding?	Yes	No	

Medications (Please enter all current medications)

Allergies (Please enter all allergies)

Social History (Please circle all that apply)

Do you smoke?	Yes	No	Have you smoked in the past?	Yes	No	
Do you drink alcohol?	Yes	No	How many drinks per day?	<1	1-2	3+
Drug Use	Yes	No				
Other _____						



What are your concerns?

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

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

- | | |
|--|---|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Micro Blepharoplasty |
| <input type="checkbox"/> Radiesse | <input type="checkbox"/> Eyebrow Lift |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Chemical Facial Rejuvenation (Peels) |
| <input type="checkbox"/> Scar Treatment | <input type="checkbox"/> Aesthetician Services |
| <input type="checkbox"/> Sclerotherapy | <input type="checkbox"/> CoolSculpt |
| <input type="checkbox"/> Liposculpture / Liposuction | <input type="checkbox"/> Silhouette InstaLift |
| <input type="checkbox"/> Lipoaugmentation | <input type="checkbox"/> Ultherapy |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Laser Tattoo Removal | |

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

	<u>Use</u>	<u>Learn More</u>
Luminous	<input type="checkbox"/>	<input type="checkbox"/>
SkinMedica	<input type="checkbox"/>	<input type="checkbox"/>
SkinCeuticals	<input type="checkbox"/>	<input type="checkbox"/>
Avène	<input type="checkbox"/>	<input type="checkbox"/>
Dr. Mercola	<input type="checkbox"/>	<input type="checkbox"/>