

ADVANCED COSMETIC & PLASTIC SURGERY

107 NEWTOWN ROAD, SUITE 2C, DANBURY, CT 06810 (203) 791-9661
901 ETHAN ALLEN HIGHWAY, RIDGEFIELD, CT 06877 (203) 438-5080

LEGAL First Name _____ Last Name _____ M.I. _____

Male Female Date of Birth ____/____/____ Age _____

Social Security # _____

Street _____ City _____ State _____ Zip _____

Home Tel. # (____) _____ Business Tel. # (____) _____ E-mail _____

Primary Doctor _____ Location (City) _____
(As listed on your insurance card)

Referring Doctor _____ Your Cell # _____

1. How would you like to improve your skin? _____
2. Do you have any history of: Chronic Acne: _____ Chronic Skin Sensitivity: _____
If yes please explain: _____
3. Have you been told you have skin cancer? Yes _____ No _____
4. Is there a history of skin cancer in your family? Yes _____ No _____
5. Do you have any allergies? Yes _____ No _____ (this includes medicine, food, fabrics, etc...)
6. Have you been told you have diabetes? Yes _____ No _____
If yes explain: _____
7. Are you pregnant or lactating? Yes _____ No _____
8. Have you ever taken Accutane? Yes _____ No _____ If Yes, When? _____
9. Do you have a history of shingles, herpes or cold sores? Yes _____ No _____ If Yes, how frequent? _____
Have the lesions been acute in the last 4 to 6 weeks? Yes _____ No _____
10. Do you currently take any oral medications, antioxidants or herbal supplements? Yes _____ No _____
If yes, please explain: _____
11. Have you used facial waxes or depilatories in the past month? Yes _____ No _____
12. Do you have any health problems? Yes _____ No _____
If yes, please explain: _____
13. Do you have any problem healing from a cut or burn? Yes _____ No _____
If yes, please explain: _____
14. Have you had chemotherapy or radiation? Yes _____ No _____
If yes, please explain: _____
15. Have you had facial peels, laser, surgery or dermabrasion? Yes _____ No _____
If yes, please explain: _____
16. What products do you use daily for your skin care? _____
17. Do you use Retinol Creams, Retin-A, Glycolic Products or other topical preparations? Yes _____ No _____
If yes, please explain the strength and frequency of use: _____
18. Do you use sun protection daily? Yes _____ No _____ Do you use tanning beds? Yes _____ No _____
19. Do you wear contact lenses? Yes _____ No _____
20. How did you hear about the skin care clinic? _____

Patient Signature (Parent or Guardian if Minor)

Parent/Guardian Date of Birth

Date

Print Name

**ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:
Notice of Privacy Practices
Informed Consent
Practice Financial Policies
Notice Regarding Ridgefield Surgical Center, LLC**

ADVANCED SPECIALTY CARE

107 Newtown Road, Danbury, CT 06810
131 Kent Road New Milford, CT 06776

901 Ethan Allen Highway, Ridgefield, CT 06877
22 Old Waterbury Road, Southbury, CT 06488

Privacy Officer: Jennifer Retter, Business Manager (203) 830-4700 ext. 265

I hereby acknowledge that I was given the opportunity to review this medical practice's Notice Of Privacy Practices (HIPAA), and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I authorize the person(s) listed below to discuss my medical information:

Name Relationship to Patient

Name Relationship to Patient

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.

Under certain circumstances, this office may need to request lab reports, radiology reports, or other diagnostic test results from outside facilities. At times these facilities may require an authorization to release such records. My signature authorizes the release of any diagnostic test results that we may require in order to provide treatment.

I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

If this office does not have a contract with my insurance company, payment must be made at the time of visit unless prior arrangements have been made. It is my responsibility to follow up on any outstanding claims sent to my insurance company, and to pay any deductible amount, co-insurance, or any other balance not paid by my insurance company. If services rendered are considered non-covered by my insurance company, I will be responsible for payment in full. My signature on file indicates that I have read and agree to the terms above. It is also an authorization to release my medical records, which may include photographs, to those physicians who may be involved in my care, as well as information necessary to process my claims. I hereby authorize payment directly to the physician named of the insurance benefits otherwise payable to me.

I hereby acknowledge that I been given an opportunity to review the posted notice to patients regarding physician ownership of Ridgefield Surgical Center, LLC.

Signature (Parent or Guardian if Patient a Minor) Relationship To Patient

Please Print Name Date

Patient's date of birth