

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 # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. # (____) _____ Business Tel. # (____) _____ Your Cell # _____

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

Referring Doctor _____ Local Pharmacy _____

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. Would you like more information about Botox, Restylane or any other facial fillers? Yes _____ No _____
17. What products do you use daily for your skin care? _____
18. 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: _____
19. Do you use sun protection daily? Yes _____ No _____ Do you use tanning beds? Yes _____ No _____
20. Do you wear contact lenses? Yes _____ No _____
21. 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 with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited.

I hereby acknowledge that I have 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

Patients Name (if Minor)

____/____/____