MEDICAL INFORMATION

GILLIE
AESTHETICS | DERMATOLOGY

PERSONAL INFORMATION

FULL NAME _____

PREFERRED NAME: _____ REFERRING PROVIDER/PCP : _____

DATE OF BIRTH : _____ / _____ / _____ SEX : ☐ Female ☐ Male

ADDRESS : _____

PHONE NUMBER : _____ EMAIL : _____

SOCIAL SECURITY NUMBER : _____ HEIGHT : _____ WEIGHT : _____

STATUS : ☐ Single ☐ Married ☐ Divorced ☐ Other

PHARMACY : _____ PHARMACY PHONE : _____

REASON FOR YOUR VISIT TODAY:

_____

ARE YOU INTERESTED IN DISCUSSING COSMETIC SKIN CARE AND TREATMENTS? ☐ Yes ☐ No
If yes, please complete attached optional aesthetic consultation form. If not, please ignore.

EMERGENCY CONTACT DETAILS

CONTACT NAME : _____ PHONE NUMBER : _____

RELATIONSHIP : _____ SECONDARY NUMBER : _____

MEDICATIONS Please list all medications including over the counter supplements.

_____

_____

_____

DO YOU TAKE Coumadin? Yes No Aspirin Yes No Blood thinners? Yes No

MEDICATION ALLERGIES ☐ None or please list below

_____

_____

+ Have you ever had a reaction to lidocaine or epinephrine? ☐ Yes ☐ No

FEMALES ONLY

ARE YOU PREGNANT? Yes No Possibly

ARE YOU BREASTFEEDING? Yes no ARE YOU TRYING TO BECOME PREGNANT? Yes No

PLEASE LIST YOUR BIRTH CONTROL METHOD(S) (If applicable) _____

HEALTH

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Please check ALL conditions you have or have had in the past :

- ☐ acid reflux
- ☐ anxiety
- ☐ arthritis
- ☐ artificial heart valve
- ☐ asthma
- ☐ back pain/injury
- ☐ depression
- ☐ diabetes
- ☐ eczema
- ☐ eye disease
- ☐ hair loss
- ☐ heart disease
- ☐ hepatitis
- ☐ high blood pressure
- ☐ hiv/aids
- ☐ hives
- ☐ implanted metal
- ☐ kidney disease
- ☐ low blood pressure
- ☐ lung disease
- ☐ lupus
- ☐ mouth ulcers
- ☐ neck pain/injury
- ☐ pacemaker/defib
- ☐ psoriasis
- ☐ seasonal allergies
- ☐ skin boils
- ☐ thyroid disease
- ☐ tuberculosis
- ☐ weight gain
- ☐ weight loss
- ☐ _____

DO YOU HAVE A HISTORY OF SKIN CANCER? If yes, type And location(s) ☐ Yes ☐ No

_____

DO YOU HAVE A HISTORY OF ANY CANCERS? If yes, type And location(s) ☐ Yes ☐ No

_____

HAVE YOU HAD ANY SURGERIES? If yes, please explain: ☐ Yes ☐ No

_____

_____

SOCIAL HISTORY

OCCUPATION _____ HOBBIES _____

DO YOU SMOKE CIGARETTES? ☐ Yes ☐ No If yes, # packs per day? _____

DO YOU USE SMOKELESS TOBACCO? ☐ Yes ☐ No If yes, what form? _____

DO YOU DRINK ALCOHOL? ☐ Yes ☐ No If yes, # drinks per week? _____

DO YOU WEAR SUNSCREEN DAILY? ☐ Yes ☐ No DO YOU INTENTIONALLY TAN? ☐ Yes ☐ No

DO YOU LIVE ALONE? ☐ Yes ☐ No ARE YOU A MILITARY VETERAN OR ACTIVE DUTY? ☐ Yes ☐ No
If yes, branch:_____

ARE YOU CURRENTLY EXPERIENCING ANY FEVER, CHILLS, OR NIGHT SWEATS? ☐ Yes ☐ No

SIGNATURE : _____ DATE : _____

PRINTED NAME: _____

CONTACT INFORMATION I HIPAA

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ADDITIONAL QUESTIONS

DO WE HAVE YOUR PERMISSION TO ...

Call you at work with medical information? ☐ Yes ☐ No

Leave a voice mail message at home? ☐ Yes ☐ No

Leave a voice mail message at work? ☐ Yes ☐ No

Leave a message with your spouse or someone who lives with you? ☐ Yes ☐ No

Communicate with you via patient portal if you set it up? ☐ Yes ☐ No

Use e-mail to communicate with you? ☐ Yes ☐ No

E-mail address: _____

WARNING: E-mail may not protect your confidential medical information. I recognize any confidential medical information transmitted by e-mail is not secure and sent at my own risk. I will not hold GILLIE Aesthetics and Dermatology responsible for the loss of any confidential medical information transmitted by e-mail. GILLIE Aesthetics and Dermatology will limit our use of unencrypted e-mail to prevent disclosure of protected health information.

Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No

Do you want a copy of the Notice of Privacy Practices? ☐ Yes ☐ No (If yes, please ask receptionist.)

May we discuss your medical information with anyone other than you? ☐ Yes ☐ No

Name(s) : _____

Relationship : _____

Phone : _____

Please list an emergency contact person (relative or friend not living with you):

Name(s) : _____

Relationship : _____

Phone : _____

I acknowledge all of the above information is correct. I authorize GILLIE Aesthetics and Dermatology to use the contact information above in treatment of my medical conditions. Please return this as well as presenting your insurance card and ID to our receptionist. They will make a copy of the cards then return to you promptly.

WE THANK YOU FOR CHOOSING US FOR YOUR SKIN NEEDS!

SIGNATURE : _____ DATE : _____

PRINTED NAME : _____

PATIENT INFORMATION & INSURANCE AUTHORIZATION

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PATIENT INFORMATION

Full Name : _____

Mailing Address : _____

City I State I Zip : _____

Primary Phone : _____ Additional Phone : _____

Employer : _____

Work Phone : _____ Social Security Number : _____

Date of Birth : _____ Age : _____

Please Circle : Single Married Divorced Other Birth Sex (Please Circle) : Female Male

PARENT, SPOUSE, OR RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Full Name : _____

Mailing Address : _____

City I State I Zip : _____

Primary Phone : _____ Additional Phone : _____

Employer : _____

Work Phone : _____ Relationship to Patient : _____

INSURANCE CARRIER INFORMATION

☐ Check if self pay.

Primary Insurance Carrier : _____ Relationship to Patient : _____

Policy Holder Name : _____ Policy Holder Date of Birth : _____

Identification Number : _____ Group Number : _____

Secondary Insurance Carrier : _____ Relationship to Patient : _____

Policy Holder Name : _____ Policy Holder Date of Birth : _____

Identification Number : _____ Group Number : _____

I authorize GILLIE Aesthetics and Dermatology to bill my insurance company for medical services rendered and receive payment directly from my insurance company. I permit a copy of this authorization to be used in place of the original and consent to the release of medication information necessary to process any insurance claims. I also consent to the release of medical information to other providers who may participate in my treatment. The information provided above is accurate to the best of my knowledge. I have read and signed the GILLIE Aesthetics and Dermatology Insurance and Billing Practices Information sheet and understand it is also available online and at my request.

SIGNATURE : _____ DATE : _____

MEDICARE QUESTIONNAIRE

ONLY IF APPLICABLE

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PATIENT NAME : _____

Please answer these additional questions regarding your Medicare insurance and benefits to help us in your care here at GILLIE Aesthetics and Dermatology.

Have your recently joined a Medicare HMO? ☐ YES ☐ NO _____
If yes, please identify

Do you or your spouse have coverage through employment? ☐ YES ☐ NO

Are you covered by another insurance with Medicare as secondary? ☐ YES ☐ NO
If yes, please identify : _____

Are you eligible for Veteran's Administration benefits? ☐ YES ☐ NO

Are you covered by the End Stage Renal Disease Program? ☐ YES ☐ NO

Are your skin problems related to an automobile accident? ☐ YES ☐ NO

Are your skin problems related to an injury at work? ☐ YES ☐ NO

Do you receive Medicaid (TennCare)? ☐ YES ☐ NO

Did your physician make this appointment for you? ☐ YES ☐ NO _____
If yes, please identify

Do you have Tricare for Life? ☐ YES ☐ NO If yes, please identify the sponsor below:

Sponsor name _____ Sponsor ID number _____

Please read and sign the following statement authorizing GILLIE Aesthetics and Dermatology to file claims to Medicare on your behalf and release protected medical information to Medicare and your insurance company for proper billing purposes. We need your signature on file to process your claims. I authorize GILLIE Aesthetics and Dermatology to release medical or other information to the Social Security Administration and Health Care Financing Administration or its intermediaries and subcontractors any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request payments of medical insurance benefits to GILLIE Aesthetics and Dermatology for medical services rendered to me. I understand regulations pertaining to Medicare assignment of benefits will apply.

SIGNATURE : _____ DATE : _____

If you have supplemental insurance, please read and sign this statement authorizing GILLIE Aesthetics and Dermatology to file claims to the supplemental policy. We need your second signature on file to process your claims to supplemental insurance policies. I request authorized benefits be paid on my behalf for any services performed by GILLIE Aesthetics and Dermatology. I also authorize the release of any medical or other information to the supplemental insurance to support payment of benefits.

SIGNATURE : _____ DATE : _____

INSURANCE & BILLING PRACTICES

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PLEASE READ THE FOLLOWING:

It is **your responsibility** to :

- Provide GILLIE Aesthetics and Dermatology with accurate information regarding your insurance, employer, date of birth, address, social security number, and other requested information to facilitate billing your insurance. This information is included on the Patient Information and Insurance Authorization forms you filled out at your initial visit. GILLIE Aesthetics and Dermatology respects your right to privacy and will maintain confidentiality of your information.

- Understand your insurance benefits regarding copays and deductibles. If you are not certain about your coverage, please investigate this **prior** to your appointment. It is your responsibility to pay your copayments, deductibles, balances, and coinsurance when you arrive for your appointment. GILLIE A I D accepts payment by cash, check, VISA, MasterCard, and Discover. There is a $30 fee for all returned checks.

- Pay for any service or cosmetic procedure not covered by your insurance provider. Costs for cosmetic services and non-medically indicated procedures not covered by insurance will be discussed with you before they are performed. We expect payment for these services on the day they are performed.

- Obtain insurance referrals from your primary care provider if your insurance requires it **prior** to your appointment. Please check with your PCP or your insurance before your appointment to guarantee your referral is in place.

- Have your insurance card and insurance information with you upon arrival for **each** appointment. If you do not have proof of insurance, you may be asked to pay for your visit.

- Pay GILLIE Aesthetics and Dermatology for medical services not paid by your insurance carrier, including claims denied because information you provided to us was not complete or accurate.

It is **our responsibility** to :

- Submit claims to your insurance carrier with whom we are contracted, for the medical services we provide during your visit.

- Provide your insurance company with the information necessary to determine the medical or surgical care you received during your visit.

- Submit claims to your secondary or supplemental insurance plans at your request. If we do not receive payments within 60 days, we will issue you a bill for the services provided.

If GILLIE Aesthetics and Dermatology is not contracted with your insurance plan, you will pay for your visit and any services rendered at your appointment. GILLIE Aesthetics and Dermatology offers reasonable rates for patients who pay for services on their own. We also offer payment plans, so please discuss options with our billing department if a financial situation arises.

If you do not pay your bills from GILLIE Aesthetics and Dermatology, you will be notified in writing and your bill referred to an outside collection agency or pursued through legal proceedings. You will be responsible for all costs associated with the collection process in addition to the fees owed to us.

DO WE HAVE YOU PERMISSION TO COMMUNICATE WITH YOU REGARDING YOUR BILL VIA TEXTING THE PROVIDED PHONE NUMBERS, EMAIL, AND PATIENT PORTAL IN addition TO THE TRADITIONAL METHODS OF PAPER STATEMENTS AND PHONE CALLS? (These methods provide a more efficient and convenient option to managing your healthcare. If you answer no, paper statements and phone calls will be the default options.)

☐ Yes ☐ No

I certify I have read the above information and had all of my questions answered. I understand and agree to the policies described above. I understand I am responsible for charges not covered by my insurance.

SIGNATURE : _____ DATE : _____

PRINTED NAME : _____

E-PRESCRIBING I RX CONSENT

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E-PRESCRIBING & MEDICATION HISTORY CONSENT

GILLIE Aesthetics and Dermatology Plc uses an electronic medical record system that allows electronic prescribing of medications. Prescriptions are sent to your pharmacy through a secure connection which improves the accuracy and timely transmission of your medical information. E-Prescribing greatly reduces medication errors and enhances patient safety. There are several standards that may be included in an e-prescription program.

THESE INCLUDE :

- Formulary and benefit transactions: Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transaction: Provides the physician with information about previous and current medications the patient is taking to minimize the number of adverse drug reactions.
- Fill status notification: Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up or partially filled.

My signature certifies that I have read and understood the scope of my consent and that I authorize the access of my medication history. This consent will remain in effect until I sign to revoke it. This consent is voluntary and I do not have to choose these options. If I decline consent, I understanding I am choosing to opt out of the above stated benefits, but this will not affect the care I receive from GILLIE Aesthetics and Dermatology Plc.

SIGNATURE: _____ DATE: _____

PRINTED NAME : _____

Aesthetic Consultation

(Optional. Please ignore this form if not interested at this time.)

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CLIENT SKIN CONCERNS

What are your main skin concerns?

- ☐ Acne
- ☐ Blackheads
- ☐ Dry Skin
- ☐ Oily Skin
- ☐ Dull Skin
- ☐ Dehydrated Skin
- ☐ Fine Lines
- ☐ Dark Under Eyes
- ☐ Dark Spots
- ☐ Melasma
- ☐ Scars
- ☐ Ingrown Hairs
- ☐ Hair Loss
- ☐ Enlarged Pores
- ☐ Redness
- ☐ Sagging Skin
- ☐ Premature Aging
- ☐ Thin Lips
- ☐ Bruising
- ☐ _____

YOUR AESTHETIC HISTORY

What procedures have you had previously?

_____

_____

YOUR SKIN TYPE

What would you say is your skin type?

- ☐ Normal
- ☐ Oily
- ☐ Sensitive
- ☐ Combination

YOUR SKIN ROUTINE

What is your current skin care routine?

_____

_____

Which of these steps are you most happy with / wanting to continue with?

_____

YOUR SKIN GOALS

Which are you interested in learning more about?

- ☐ Toxins (Daxxify, Botox, Dysport, etc.)
- ☐ Fillers (RHA, Restylane, Juvederm, etc)
- ☐ PRP/PRF
- ☐ Thread "Lifts"
- ☐ Chemical Peels
- ☐ Microneedling
- ☐ Skin Care
- ☐ Facials
- ☐ Natural options
- ☐ _____

SIGNATURE : _____ DATE : _____

PRINTED NAME: _____