



STONE DERMATOLOGY

14460 Lakeside Circle, Suite 100
Sterling Heights, MI 48313
P: 586.685.3285 F: 586.685.3286

Stone.Derm@gmail.com | www.StoneDermatology.com

Medical History Form

Patient Name _____ DOB _____ Age _____
 Marital Status: Single Married Divorced Widow Separated | Can you care for yourself? Yes No
 Reason for today's visit _____
 Could you be pregnant now or are you breastfeeding? Yes No Male

Medications: Please list all medication that you are currently taking.

Allergies: Yes No Please list all medications that cause allergic reactions.

Check the box that best describes your medical condition:

Diseases	Never	Prior	Current	Diseases	Never	Prior	Current
Aids / HIV Positive				Kidney Disease			
Arthritis/Bone/ Joint				Lupus			
Asthma				Lung or Respiratory			
Bleeding Tendencies				Neurological / Seizures			
Cancer				Psychiatric			
Circulation Problems				Psoriasis			
Coronary Heart Disease				Sexually Acquired Disease			
Diabetes				Skin Cancer			
Eye Disease				Stomach / Digestive			
Hair Loss (Sudden)				Stroke			
Headaches				Thyroid Disease			
Hepatitis				Tuberculosis			
Herpes				Urinary Tract Disease			
High Blood Pressure				Other			
Hives				Other			

Hospital or Serious Injuries: Please list major surgeries, hospitalizations or serious injuries:

	Year

Substance Abuse	Never	Yes	No
Tobacco Use: If yes, Daily: _____ Packs per day: _____			
Alcohol Use: If yes, Number of drinks per Day: _____ Week: _____			
Drug Use: If yes, Type and Frequency: _____			
Skin Irritant Exposure: If yes, Type and Frequency: _____			

Family History (Please list family members with skin disease)

Relation	Age	Disease

Reviewed and Updated By (OFFICE USE ONLY): _____ Date _____



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Acknowledgment of Receipt of Privacy Practices

I hereby acknowledge receipt of notice of privacy practice, which details the use and disclosure of my protected health information by the offices of RICHARD A. STONE, M. D.

I understand that signing this acknowledgment does not mean that I agree with the contents of the Notice of Privacy Practices.

I understand that I may receive further copies of the Notice of Privacy Practices in the future as revisions are made, or should I require additional copies.

If at any time I have questions concerning the Notice of Privacy Practices, I understand that I may have all my questions answered by contacting the Privacy officer at the offices of RICHARD A. STONE, M. D.

Signature of Patient/ Representative

Date

Printed Name

If acknowledgement is not obtained, document below the good faith efforts to obtain the acknowledgement and the reason why is was not obtained:

Patient Name

Date

Reason acknowledgment was not obtained (describe reason, such as an emergency treatment situations or substantial barrier to communication:

Signature of Associate

Date



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Patient Name: _____ Date of Birth: _____

Please Read Carefully

YOU ARE DIRECTLY RESPONSIBLE FOR PAYMENT OF CARE PROVIDED BY THIS OFFICE

Payments for any uncovered services, cosmetic, and co-pays must be paid at the time of service. This also includes treatments not covered as a contractual benefit, procedures judges to be not medically necessary, and any visits where required authorizations or referrals were not obtained. In order to serve you, we accept cash, personal checks, Visa, MasterCard, Discover, and AMEX. We are not permitted to bill your insurance company for procedures that are not covered, including any cosmetic services. We will submit a claim for covered procedures to insurance companies that we participate with.

- ★ Please let us know if you have special financial needs or circumstances.

Authorizations And Acknowledgments

1. I have read and understand the payment policy.
2. I authorize insurance benefits to be paid, if necessary, directly to the physician.
3. I authorize the release of my medical information to my medical insurance carriers.
4. **I authorize the physician, the physician assistant, and staff under the physician's supervision to provide me with reasonable and proper medical care consistent with today's standards to include, but not limited to:**
 - a. **Diagnosis and treatment.**
 - b. **Surgical procedures of the skin involving, removal, destruction, and application of dermatologic treatment agents, upon discussion and verbal agreement.**
5. I acknowledge being offered a copy of the Notice of Privacy Practices.

To which family members, if any, can we release your medical information?

- If none please write "none" on the line and sign below
- Otherwise, please list the name of the family member and the relationship to the patient.

Name of Family Member: _____

Relationship to Patient: _____

Signature of Patient or Responsible Party

Date



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COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ DOB: _____

The providers and staff at Stone Dermatology provide comprehensive dermatological care. In addition to general dermatology, we also provide an array of skin care products and cosmetic services. We would greatly appreciate if you would take a minute and indicate areas of interest to you. Please check all that apply if you are interested in discussing any during this visit.

- | | |
|----------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Skin Care Advice | <input type="checkbox"/> Sunspots/Age Spots |
| <input type="checkbox"/> Skin Care Products | <input type="checkbox"/> Acne Scarring |
| <input type="checkbox"/> Sunblock | <input type="checkbox"/> Scars |
|
 | |
| <input type="checkbox"/> Chemical/Glycolic Peels | <input type="checkbox"/> Birthmarks |
| <input type="checkbox"/> Facials | <input type="checkbox"/> Facial Veins |
| <input type="checkbox"/> Micro Dermabrasion | <input type="checkbox"/> Facial Redness |
| <input type="checkbox"/> Acne Treatment | <input type="checkbox"/> Facial Rejuvenation |
|
 | |
| <input type="checkbox"/> Spider Vein Treatments | <input type="checkbox"/> Hair Removal |
|
 | <input type="checkbox"/> Tattoo Removal |
| <input type="checkbox"/> Facial Fine Line/Wrinkles | <input type="checkbox"/> Body Sculpting, Fat Reduction, Skin Tightening & Cellulite Appearance Reduction |
| <input type="checkbox"/> Botox® Cosmetic | <input type="checkbox"/> Wrinkle Reduction |
| <input type="checkbox"/> Fillers | |
| <input type="checkbox"/> Thin Lips | |
| <input type="checkbox"/> Chin Fat/Double Chin | <input type="checkbox"/> Ear Piercing |

How did you hear about us?

- A friend or family member? (name) _____
- Advertising in Newspaper
- Internet
- Other _____

Are you interested in receiving information on products, services, promotions, special offers and events?

- ❖ Yes
- ❖ No

If yes, please provide preferred contact method:

- Email Address _____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

Provider Signature: _____ Date: _____