Beer Dermatology
Cosmetic, General and Surgical Dermatology

Kenneth Beer, M.D., Alejandro Rabionet, M.D., Patrick M. Zito, D.O, Pharm D., Anne Wade, PA-C

PLEASE COMPLETE BOTH SIDES OF THIS INFORMATION FORM

Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___
First Middle Last

Local Address: _____
Street Apt# City State Zip Code

Summer Address: _____
Street Apt# City State Zip Code

Home Phone Number: ( )_____ Summer Phone Number: ( ) _____

Mobile Phone Number: ( )_____ e-mail address: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed *Instagram Handle: _____

Age:_____ Sex: ❑ Male ❑ Female Social Security Number: _____/_____/_____

Spouses Name: _____

Insured Name: _____

Party Responsible For Payment: _____

Primary Insurance/Medicare: _____

Insured Date Of Birth:_____/_____/_____

Address: _____

Policy Number:_____

Do you have a secondary carrier? ❑ Yes ❑ No

Name of Company:_____ Policy Number: _____ Group Number: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Medical History:

Who Referred You to Our Office? _____ Family Physician: _____

Do you have an artificial heart valve, joint or other prosthesis that requires you to take antibiotics when you have dental procedures? ❑ Yes ❑ No If yes, what antibiotic:_____

Are you allergic to Bandaids, tape or adhesive? ❑ Yes ❑ No

Do you have a history of skin cancer or skin disease? ❑ Yes ❑ No If yes, what type? _____

Please list any other information that we need to know about: _____

Female Patients Only: Are you taking oral contraceptives? ❑ Yes ❑ No

Are you pregnant or trying to become pregnant? ❑ Yes ❑ No

HIP AA Contact List:

Beer Dermatology and Staff have my permission to speak to the following family members/friends in reference to my medical care:

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

We offer a full range of cosmetic procedures:

Please indicate whether you are interested in learning more about:

❑ Botox ❑ Dysport ❑ Restylane ❑ Radiesse ❑ Sculptra ❑ Juvederm ❑ Perlane ❑ Isolaz for Acne

❑ Fraxel ❑ Laser for Rosacea ❑ Laser Hair Reduction ❑ Intense Pulse Light Treatment ❑ Smoothshapes

❑ Treatment of Veins ❑ Dr. Beer's Skincare Line ❑ Sunscreens ❑ Clinical Trials ❑ Cool Sculpting

❑ Clear & Brilliant

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GUARANTOR AGREEMENT:

By signing this form as Patient/Guardian/Agent, I hereby agree that any and all charges that arise within the treatment, past or future treatment if related to the incident or condition giving rise to this admission or service, not covered by any insurance, program, sponsorship, or other third party coverage I may have are due and payable by me at the time of discharge or discontinuation of treatment. I hereby acknowledge that Beer Dermatology; Kenneth Beer, M.D.; Alejandro Rabionet, M.D.; Patrick M. Zito, D.O, Pharm D., Anne Wade, PA-C has agreed to bill my insurance or other third party carrier and has agreed to do so as a courtesy and Beer Dermatology; Kenneth Beer, M.D.; Alejandro Rabionet, M.D.; Patrick M. Zito, D.O, Pharm D.; Anne Wade, PA-C has the right to demand payment in full from me at any time prior to full payment from any insurance carrier or third party unless it is contractually stated that I will not be billed. I hereby acknowledge that I have been told, prior to receiving treatment, that I will be billed by Beer Dermatology; Kenneth Beer, M.D.; Alejandro Rabionet, M.D.; Patrick M. Zito, D.O, Pharm D.; Anne Wade, PA-C. I further agree that if I am more than thirty (30) days late in the payment of any bill connected with this treatment, and past treatment, a finance charge of 1.5% per month will accrue on the unpaid balance; and if the delinquent account is referred to a collection agency and/or attorney, I agree to pay the attorney's fees, court costs and collection agency fees associated with the collection process.

I understand that any lab charges (including pathology services performed by my physician or another physician) are separate from the charges for my medical care. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments.

Note: **If your secondary is an automatic crossover, Medicare will send the claim automatically to them. If not, you are responsible for your deductible and 20% copay at the time service is rendered. You will need to send your Medicare explanation of benefits in to your secondary carrier. If your secondary is a crossover but fails to pay in a timely fashion, you are ultimately responsible for the 20% copay that Medicare does not pay.but fails to pay in a timely fashion, you are ultimately responsible for the 20% copay that Medicare does not pay.**

MISSED APPOINTMENTS & NSF FEE:

In order to provide the best possible service and availability to all our patients it is our policy to charge a $300 fee for any appointments not canceled at least 24 hours prior. Please call us as early as possible if you know you will need to reschedule your appointment. There will be a $30 Non Sufficient Funds fee for any returned checks.

CONSULT FEES:

There will be a charge payable at time of service for any cosmetic consultation or service performed. In the instance the bill is unpaid, there is a service and collection fee as well as legal fees. I have read and understand the financial policy stated above and authorize the release of any information necessary to process my claims. As a member of a managed care group, I assume all responsibility for any services rendered that are or are not part of my referral, whether or not covered or paid by my insurance and I will pay for those services at the time they are needed.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

SIGNATURE:_____

DATE:_____

Beer Dermatology

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BEER DERMATOLOGY
COSMETIC, GENERAL & SURGICAL DERMATOLOGY

NAME: _____ D.O.B : _____ DATE: _____

List all current medications, vitamins, and OTC: _____

_____

_____

Pharmacy name and phone number: _____

Primary Care Physician: _____

Medical History (Circle the following medical conditions that apply to you):

Anxiety	End Stage Renal Disease	Pacemaker/Defibrilator	Eczema
Arthritis	GERD (Reflux Disease)	Prostate Cancer	Psoriasis
Asthma	Hearing Loss	Radiation Treatments	Lupus
Atrial Fibrillation	Hepatitis	Seizures	Basal Cell Skin Cancer
Bone Marrow/Organ Transplant	High Blood Pressure	Stroke/TIA	Squamous Cell Skin Cancer
Benign Prostatic Hyperplasia	High Cholesterol	Blistering Sun Burns	Melanoma
Breast Cancer	HIV/AIDS	Bleeding Tendency	Actinic Keratosis
Colon Cancer	Hyperthyroidism	Heart Attack	Acne
Pulmonary Disease / COPD	Hypothyroidism	Stomach Ulcers	Keloids
Coronary Artery Disease / Heart Disease	Leukemia/Lymphoma	Joint Replacement	Herpes Virus/ Cold Sores
Depression	Lung Cancer	Cataracts	Mohs Surgery
Diabetes	Heart Valve Replacement	Glaucoma	Auto Immune Disease

Do you have a family history of skin cancer? Yes No If yes please list: _____

Please list all surgeries you have had in the past 5 years: _____

_____

_____

Please list any allergies you have: _____

_____

Do you have a living will? Yes No

Have you had the flu shot? Yes No Have you had the pneumonia shot? Yes No