Acri Dermatology, P.A.
8100 Sandpiper Circle, Suite 208
White Marsh, MD 21236
Phone: 410-931-2274
Fax: 410-931-2273

Dear New Patient,

Welcome to the Dermatological practice of Acri Dermatology, P.A.

Enclosed please find paperwork for you to complete and bring with you to your appointment on

_____at _____.

It is important to bring your insurance card (s), a referral if your insurance requires one, and your co-pay. If you are unsure whether a referral is needed, please call member services listed on your insurance card and or your primary care physician, as they will be the one to issue you a referral if you need it. Please note that if your insurance does require a referral and you do not have one at the time of your visit, you will be expected to either pay for your visit in full or reschedule your appointment. We accept personal checks, Visa, Master Card, Discover and cash.

According to the Red Flag Regulations Law, we now require that you provide proper identification for our office to keep on file, such as your driver's license. If you do not have a driver's license, then you will need to provide two forms of identification (birth certificate, social security card, credit card, etc).

If you cannot keep your appointment and or need to reschedule your appointment, please call our office at 410-931-2274.

We look forward to meeting you.

Sincerely,

Dr. Acri's Staff

Patient Registration

Today's Date: _____

Name_____
Last Name First Name MI

Address_____
City State Zip

Home Phone_____Work Phone_____Cell Phone_____

Date of Birth_____Social Security #_____ Sex: _____Marital Status_____

E-Mail _____

Responsible Party if Different From Patient:

Name_____
Last Name First Name MI

Address_____
City State Zip

Home Phone_____Work Phone_____Cell Phone_____

Date of Birth_____ Social Security #_____ Sex:_____

INSURANCE INFORMATION PLEASE

Primary Insurance Name_____
Ins. Address_____
Name of Insured_____
ID#_____
Group#_____
Date of Birth_____
Relationship to Patient _____
Employer_____
Employer Address_____
Employer Phone_____

Secondary Insurance Name_____
Ins. Address_____
Name of Insured_____
ID#_____
Group#_____
Date of Birth_____
Relationship to Patient _____
Employer_____
Employer Address_____
Employer Phone_____

Pharmacy_____Phone_____

In case of emergency contact_____Phone_____

Referred By_____Primary Care Physician_____

Patient's Signature Page

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance application and prescriptions. I also authorize payment of medical benefits to the physician.

Patient's Signature Date

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of their office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. In the event that your account must be turned over to collections, a $20.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient's Signature Date

I, _____, have received and or read a copy of Acri Dermatology, P.A's Notice of Privacy Practices.

Patient's Signature Date

We ask that you kindly give our office 24 business hours notice of cancellation. If this is not given, there will be a $25.00 No Show Fee charged per occurrence.

Patient's Signature Date

Office Staff Signature Date

Acri Dermatology, P.A.
Nadine B. Acri, M.D.

PATIENT AUTHORIZATION

Due to the new federal patient confidentiality laws (HIPPA), the office will need your permission to do the following:

Confirm Appointments via telephone ____Yes ____No

Leave lab and or biopsy results and messages:

Name of person (s) _____
Other then patient

____Answering machine ____No one ____Anyone

By signing this authorization form, I fully understand that I am giving the dermatological office of Dr. Nadine Acri permission to do the above. I may cancel or change this authorization at any time.

Patient's Signature Date

Acri Dermatology, P.A

Name _____ Date _____ D.O.B. _____

Drug Allergies:
Current Medications:

Past Medical History **Please Check All That Apply**

o Pacemaker	o Asthma	o Hayfever	o Eczema	o Keloids
o Artificial Joints	o Diabetes	o Coronary Heart Dis.	o High Blood Pressure	o Hepatitis
o Bleeding Disorders	o Arthritis	o Lupus	o Kidney Disease	o Anemia

Other Major Illnesses:

If applicable could you be pregnant? ____Yes ____No
Personal history of skin cancer. ___Basal Cell ___Squamous Cell ___Melanoma ___Unknown
Location of Cancer:

Family Medical History

o Hayfever	o Psoriasis
o Asthma	o Eczema
o Basal Cell Cancer	o Squamous Cell Cancer
o Melanoma	o Unknown o None

Do you have a history of Sun Exposure? ___Yes ___No

Social History/Occupation:
Reason for your visit today?

PLEASE DO NOT WRITE BELOW THIS LINE

ROS: _____Feeling Well_____other skin complaints_____Weight loss

PHYSICAL EXAMINATION:

Constitutional: Well Developed_____Well Nourished_____Obese_____Cachectic_____VS_____

Neuro/psych: Normal_____Abnormal_____

Ear/Nose/Mouth/Throat: Normal_____Abnormal_____

Eye: Normal_____Abnormal_____

Neck: Normal_____Abnormal_____

Cardiovascular: Normal_____Abnormal_____

Gastrointestinal: Normal_____Abnormal_____

Lymphatic: Normal_____Abnormal_____