



Metrolina Dermatology  
and Skin Surgery Specialists

Metrolina Dermatology and Skin Surgery Specialists  
10502 Park Road, Suite 100  
Charlotte, NC 28210  
[www.metrolinadermatology.com](http://www.metrolinadermatology.com)

Phone: 980-299-3926  
Fax: 980-299-3926

Dear Patient,

We thank you for choosing Metrolina Dermatology and Skin Surgery Specialists for your dermatologic needs. We look forward to seeing you at your upcoming appointment. The following information is intended to make the registration process easier and more efficient. In order to expedite the registration process, please complete the following forms. By completing these forms ahead of time, you will save a significant amount of time during your visit. You can also complete these online using our patient portal located on our website at [www.metrolinadermatology.com](http://www.metrolinadermatology.com). However, if you prefer to fill these forms out in the office, please arrive 30 minutes prior to your appointment time.

Please be prepared to provide the following at your appointment:

- Completed forms
- Current medical insurance care
- Photo identification
- Updated list of current medications
- A referral IF your insurance requires a referral

If have a specialist co-pay, we will collect that at time of service.

To allow for sufficient time for the registration process, please arrive 15 minutes prior to your first appointment, or 30 minutes if you choose to complete the forms in our office. We ask you to arrive prior to your appointment time in order to fill out these forms in order for our office to run smoothly and to respect every patient's time. If you arrive 5 minutes past your appointment, we will have the right to re-schedule you.

We appreciate your assistance with preparing for your appointment, and we look forward to providing you the highest quality dermatological care. If you have any questions or concerns regarding the registration process, or any questions about your appointment, please do not hesitate to contact our office.

Sincerely,

Sasha Haberle, MD

Patient Registration Form: PATIENT INFORMATION			
Name:		Date of Birth:	Sex:
Street Address:		City/State:	Zip Code:
Race:	Ethnic Group:	Preferred Language:	<b>Marital Status:</b> Single   Married   Divorced   Widowed
Email address:			
<b>Employer/Place of Employment:</b>		<b>Employer Phone number:</b>	
Social Security Number:	Spouse Name (if applicable):	Caretaker Name (if applicable):	
<b>Pharmacy: *our office does electronic prescriptions – please list as much information as possible*</b> Name: _____ Location: _____ Phone: _____			
<b>Have you ever been seen by one of our physicians?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   (if yes, physician name)			
<b>Primary Care Provider:</b> Full Name: _____ Location: _____ Phone: _____ Fax: _____   Did your Primary Care Provider refer you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Did another physician refer you?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF yes:</b> Name of referring Provider _____			
<b>Emergency Contact:</b> Name/Relationship: _____ Phone: _____			

Medical Information Release (Privacy Policies are located at the reception desk)	
Cell Phone: (    )	May we leave a detailed message regarding test results, appointments, and/or billing? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message for you to return our call? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone: (    )	May we leave a detailed message regarding test results, appointments, and/or billing? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message for you to return our call? <input type="checkbox"/> Yes <input type="checkbox"/> No
Work Phone: (    )	May we leave a detailed message regarding test results, appointments, and/or billing? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message for you to return our call? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Circle your preferred contact method</b> <b>Cell</b> <b>Home</b> <b>Work</b> <b>Email</b>	
If you are not available may we leave a message with another person? If yes, please state below:  Name/Relationship _____ Name/Relationship _____  <b>Signature</b> _____ <b>Date</b> _____	

Insurance Information	
Insurance Name: _____	Relationship to patient: _____
Primary Subscriber Name: _____	Primary Subscriber Date of Birth: _____
<b>Recent insurance policy changes and the popularity of high deductible plans have increased the number of bills and balances to patients. If you have not met your deductible for your plan year, please expect a bill from our office. Per our insurance contracts, we are unable to make adjustments to any outstanding balance.</b>	



## Notice of Privacy Practices, Financial and Cancellation Policies

Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Thank you for choosing Metrolina Dermatology and Skin Surgery Specialists. The following is our notice of privacy practices, financial policy and cancellation. Please review the policy, initial where indicated, sign and date at the bottom.

**Notice of Privacy Practices:** We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our staff to acknowledge that you have been provided a copy of our notice.

**Paperwork:** We request you routinely update your paperwork to ensure we have all the correct information on hand for billing purposes and to ensure excellent clinical care. This paperwork allows us to bill insurance in a timely manner and from preventing balances being unnecessarily transferred to you, the patient. We understand the frustration of completing paperwork and are constantly evaluating different methods to reduce the burden on you.

**Missed appointments/Cancellations:** We request a 24 hour advanced notification of cancellations and reschedules. We try to notify all patients of upcoming appointments using our computerized calling system and/or by reminder phone calls directly from the office. Unfortunately, we do experience errors with the system from time to time. We do not charge for missed appointments or cancellations. **Three (3) missed appointments and cancellations can result in dismissal from our practice.**

Initial: \_\_\_\_\_

**Insurance:** Our practice is contracted with most commercial insurances and Medicare. We do not accept Medicaid. As a contracted provider, we agree to accept adjusted fees from your insurance company and bill in accordance with CPT and ICD 10 guidelines. We collect co-pays at the time of visit. Deductibles and other outstanding balances will be billed to you, after your claim has been processed by your insurance company. We are unable to determine prior to your visit what charges will be applied to your deductible. The patient is responsible for providing the most up to date insurance information prior to, or at the time of service. Patient is responsible for payment of services rendered in the event the incorrect insurance information was provided at the time of service.

Initial: \_\_\_\_\_

**Cosmetic Procedures:** For all cosmetic and laser procedures, **payment is expected in full at the time of procedure**

Initial: \_\_\_\_\_

**Lab Fee:** Metrolina Dermatology and Skin Surgery Specialists use an outside laboratory for pathology services. The lab will bill you directly for these services.

Initial: \_\_\_\_\_

**Patient is Responsible for Total Charge:** Patients will be billed in full for any unpaid copayments or deductibles. Patient balances will be set by the adjusted rates as determined by our contract with your insurance company. In accordance with our contracts and Medicare guidelines we cannot make adjustments to these fees or the codes charges. If your insurance requires a referral and the necessary referral was not obtained prior to services rendered, the patient (or party responsible for billing as listed below) is responsible for total payment of services rendered. Any remaining balance must be paid before being seen for future appointments.

Initial: \_\_\_\_\_

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**My signature below indicates that I have read and agree to the above written Notice of privacy practice, financial policy, and cancellation policy of Metrolina Dermatology and Skin Surgery Specialists. I authorize release of any medical information necessary to process any claims filed**

\_\_\_\_\_  
Signature of Patient (or Legal Representative)

\_\_\_\_\_  
Date



### Metrolina Dermatology and Skin Surgery Specialists Intake Form

Account Number: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name of Referring Medical Professional/Primary Care Provider: \_\_\_\_\_

Drug Allergies:  Yes  No

Latex Allergy:  Yes  No

If yes, list any drugs you are allergic to: \_\_\_\_\_

**Part 1: Past Medical History** (please circle all that apply)

- |                                    |                         |                      |
|------------------------------------|-------------------------|----------------------|
| Anxiety                            | Diabetes                | Lung Cancer          |
| Arthritis                          | End Stage Renal Disease | Lymphoma             |
| Asthma                             | GERD                    | Prostate Cancer      |
| Atrial Fibrillation                | Hearing Loss            | Radiation Treatments |
| Bone Marrow Transplant             | Hepatitis               | Seizures             |
| BPH (benign prostatic hyperplasia) | High Blood Pressure     | Stroke               |
| Breast Cancer                      | HIV/AIDS                |                      |
| Colon Cancer                       | High Cholesterol        | NONE                 |
| COPD/Emphysema                     | Hyperthyroidism         |                      |
| Coronary Artery Disease            | Hypothyroidism          |                      |
| Depression                         | Leukemia                |                      |

Other: \_\_\_\_\_

**Part 2: Past Surgical History** (please circle all that apply)

- |  |   |
|--|---|
| NONE   | Liver Hepatectomy                       |
| Appendix (Appendectomy)                          | Liver Transplant                        |
| Bladder (Cystectomy)                             | Liver Shunt                             |
| Breast: Breast Biopsy                            | Oophorectomy: Endometriosis             |
| Breast Lumpectomy (Bilateral, Left, Right)       | Oophorectomy: Ovarian Cancer            |
| Breast Mastectomy (Bilateral, Left, Right)       | Oophorectomy: Ovarian Cyst              |
| Colectomy: Colon Cancer Resection                | Ovaries: Tubal ligation                 |
| Colectomy: Diverticulitis                        | Pancreatectomy                          |
| Colectomy IBD                                    | Prostate Biopsy                         |
| Colostomy  | Prostate Cancer                         |
| Gallbladder Removal                              | Prostate TURP (transurethral resection) |
| Biological Heart Valve Replacement               | Rectum: Low anterior resection or ARP   |
| Coronary Artery Bypass                           | Skin: Basal Cell Carcinoma              |
| Heart Transplant                                 | Skin: Melanoma                          |
| Mechanical Valve Replacement                     | Skin: Biopsy                            |
| Heart: PTCA (percutaneous coronary angioplasty)  | Skin: Squamous Cell Carcinoma           |
| Joint Replacement, Hip (Bilateral, Left, Right)  | Splenectomy                             |
| Joint Replacement, Knee (Bilateral, Left, Right) | Testicles: Orchiectomy                  |
| Kidney Biopsy                                    | Hysterectomy: Fibroids                  |
| Kidney Stone Removal                             | Hysterectomy: Uterine Cancer            |
| Kidney Transplant                                | Hysterectomy: Cervical Cancer           |
| Kidney Nephrectomy                               |   |

Other: \_\_\_\_\_

Signature of responsible party/date \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Part 3: Skin Disease History** (please circle all that apply)

Acne  
Actinic Keratoses  
Asthma  
Basal Cell Skin Cancer  
Blistering Sunburns

Dry Skin  
Eczema  
Flaking or Itchy Scalp  
Hay Fever/Allergies  
Melanoma

Poison Ivy  
Precancerous Moles  
Psoriasis  
Squamous Cell Skin Cancer  
NONE

Other: \_\_\_\_\_

Do you wear Sunscreen?  Yes  No  
If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?  Yes  No

Do you have a family history of Melanoma?  Yes  No  
If yes, which relative(s)? \_\_\_\_\_

**Part 4: Medications** (please enter all current medications, supplements and OTC medications; include strength and dosage if known)

Medication Name	Dosage	Frequency	Route (oral, IV, IM)

**Part 5: Allergies** (please enter all allergies and type of reaction for each)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Part 6: Social History** (please circle all that apply)

**Cigarette/Tobacco Use:** Never used  
Former user  
Current user  
Packs per day: \_\_\_\_\_  
How many years? \_\_\_\_\_  
Date started/quit: \_\_\_\_\_

**Alcohol Use:** None  
less than 1 drink per day  
1-2 drinks per day  
3 or more drinks per day

**Occupation:** \_\_\_\_\_

**Part 7: Family History** (only first degree relatives: parents, sibling, children)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of responsible party/date \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Part 8: Miscellaneous**

Have you ever tested positive for TB?  Yes  No

Have you ever received your flu vaccination?  Yes  No  
If yes, what year? \_\_\_\_\_

Have you received your pneumonia vaccination?  Yes  No

**Preferred Pharmacy:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_

**Part 9: Review of Systems:** Are you *currently* experiencing any of the following?

Problems with bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Grey Discoloration of Skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Sore Throat <input type="checkbox"/> Yes <input type="checkbox"/> No
Problem with healing <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with scarring (hypertrophic or keloid) <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Unintentional weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunosuppression <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Candidiasis <input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Aches <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, indicate year _____ )	Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No
Bloody Stool <input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual Changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eye <input type="checkbox"/> Yes <input type="checkbox"/> No
Bloody Urine <input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No	Tearing <input type="checkbox"/> Yes <input type="checkbox"/> No
Blurry Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Night Sweats <input type="checkbox"/> Yes <input type="checkbox"/> No	Uncontrolled blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Rash/Hives <input type="checkbox"/> Yes <input type="checkbox"/> No	Elevated Blood Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No
Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fever or Chills <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleeplessness <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Part 10: Alerts:**

Allergy to adhesive <input type="checkbox"/> Yes <input type="checkbox"/> No	Ebola risk: fever > 100.4 <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy to lidocaine <input type="checkbox"/> Yes <input type="checkbox"/> No	West Africa: travel or contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy to topical antibiotic ointments <input type="checkbox"/> Yes <input type="checkbox"/> No	Ebola risk: contact w/ ebola patient without proper protective equipment within the last 21 days <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Ebola risk: headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain and/or hemorrhage <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints in last 2 yrs <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood thinners <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Medications <input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No	Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No
MRSA <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	
Currently Pregnant or planning a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Premedication prior to procedure <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rapid heartbeat with epinephrine <input type="checkbox"/> Yes <input type="checkbox"/> No	

Signature of responsible party/date \_\_\_\_\_



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and Skin Surgery Specialists

### Medical Photography Consent Form

I consent for medical photographs to be made of me or the person for whom I am legal guardian **FOR MY MEDICAL RECORD** to document your dermatological care. By consenting to these medical photographs I understand that I will not receive payment from any party. By signing this form below I confirm that this consent form has been explained to me in terms that I understand. Refusal to consent to photographs will in no way affect the medical care I receive. If I have any questions or wish to withdraw my consent, I will contact the office.

Patient /Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date \_\_\_\_\_

In addition, I confirm that I consent for medical photographs to be used for the following purposes: **Circle those that apply.**

- 1) for teaching and consultation with other physicians
- 2) for medical publications including textbooks and research studies
- 3) for promotional and marketing materials for Metrolina Dermatology, including electronic publications such as websites

I understand that identifying information, such as my name, will never be associated with these images. Refusal to consent to photographs will in no way affect the medical care I receive. If I have any questions or wish to withdraw my consent, I will contact the office. By consenting to these medical photographs I understand that I will not receive payment from any party. By signing this form below I confirm that this consent form has been explained to me in terms that I understand.

I understand that my photographs may be seen by physicians, scientists/researchers and members of the general public. In addition, while every effort will be made to obscure identifying features such as eyes or identifying tattoos, I understand that it is possible that someone may recognize me.

Patient /Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date \_\_\_\_\_