# Dr. Laura Ellis

Providing patients with the tools, products and programs to live happier, be healthier and look better.

30 Town Square Blvd, Suite 218 Asheville, NC 28803
P: 828-684-1212 F: 828-684-1103

**Patient Information:**

Name: ________________________________

Address:_______________________________

City:____________ State/Zip: _____________

Home Phone: ___________________________

Cell Phone: ____________________________

Work Phone: ___________________________

Email: ________________________________

Date of Birth: _____________ Age: _________

Occupation: ___________________________

Employer: _____________________________

Primary Care Doctor:______________________

Primary Care Phone: ______________________

Referring Doctor: _________________________

Referring Doctor Phone: ___________________

How did you hear about us?: ________________

__________________________________________

**Assignment of Benefits- Financial Agreement:**

I hereby give my authorization for insurance benefits to be made directly to Laura Ellis MD Skin Care & Vein Centre, PLLC. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release my insurance company all information necessary to procure the payment of benefits.

Patient signature: __________________________________ Date: ________________________

**We are a fragrance free office, please respect our patients and staff in this matter. Thank you!**

**Patient signature:**

________________________________________

**Medical History:**

Circle all that apply:

Yes No high blood pressure
Yes No low thyroid
Yes No liver disease or hepatitis
Yes No lung disease
Yes No heart disease
Yes No diabetes
Yes No HIV infection
Yes No kidney disease
Yes No acid reflux
Yes No bleeding tendency
Yes No acne
Yes No depression
Yes No epilepsy/seizures
Yes No anxiety
Yes No skin cancer
Yes No asthma
Yes No high cholesterol
Yes No arthritis
Yes No keloid scarring
Yes No tuberculosis
Yes No herpes, cold sores or shingles
Yes No blood clots in legs
Yes No blood clots in lungs
Yes No leg swelling
Yes No glaucoma
Yes No family history of glaucoma
Yes No rosacea
Yes No use Retin-A products?
Yes No use tanning booths?
Yes No smoke, How much?___________
Yes No alcohol use (#?_____/week/month)
Yes No think you are pregnant?

Date of last period_____________
Any other illnesses?
__________________________________________
__________________________________________
__________________________________________

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List all medications that you take:
Name and dose/frequency
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________

List all allergies to medications:
__________________________________________
__________________________________________
__________________________________________
__________________________________________

Yes No Are you allergic to iodine?

Yes No Are you allergic to latex?

Past surgical history:

__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________

____________________________________________ Date: ________________________________________

# Laura Ellis, MD Skin Care & Vein Centre, PLLC

**30 Town Square Blvd, Suite 218 Asheville, NC 28803**

**828.684.1212 LauraEllisMD.com**

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the Notice of Privacy Policies by the staff of Laura Ellis MD Skin Care & Vein Centre, PLLC, detailing how my information may be used and disclosed as permitted under the federal and state laws. I understand the contents of the notice and I request the following restrictions concerning the use of my personal medical information:

_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Further, I permit a copy of the authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment benefits apply.

Signed:__________________________________ Date:____________________

If not signed by patient, please indicate relationship to patient:

Relationship:______________________________ Witness:_____________________

If the patient refuses to sign, indicate your attempt to obtain a signature below:

_________ Patient refused to sign this acknowledgement

Date:________________________________

Time:________________________________

Employee:______________________________