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 Dr. Phone: ____________________

How did you hear about us?: _______________

Insurance Information:

Is your insurance policy an Affordable Care Act policy?

YES or NO

Primary Insurance: ________________________

Name of Insured: _________________________

Member ID #: ____________________________

Policy Holder: ____________________________

DOB of Policy Holder: ______________________

Secondary Insurance: _____________________

Name of Insured: _________________________

Member ID #: ____________________________

Policy Holder: ____________________________

DOB of Policy Holder: ______________________

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!

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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?
____
____
____

Patient signature:

____

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:
____

Medical History continued:

	Yes or No? /Which side? /When?
Any family history of varicose veins? Who?	
An injury to either of your legs that required an operation or casting?	
A Deep Vein Thrombosis (DVT) aka a blood clot in your leg?	
Phlebitis?	
A venous stasis ulcer?	
Hemorrhage from a varicose vein?	
Sclerotherapy?	
Vein Stripping?	
Other surgeries?	

Chief Complaint:	
For Relief of Symptoms I...: (circle all that apply) Wear support hose Limit activities Take time off work Take pain medication	Excercise Lose weight Elevate legs Take oral analgesics

For Women only:	
Pregnant or think you might be Currently nursing Planning on having more children	Taking oral contraceptives On hormone replacment therapy

Signed:_____________________________________ 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:_______________________________