



**SHIDELER
DERMATOLOGY
GROUP**

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Dear Patient,

We are very glad that you have chosen Shideler Dermatology Group. Our goal is to ensure all our patients have a comfortable and positive experience, while in our care.

In order to expedite your check-in process, please fill-out the registration forms you have downloaded and bring them with you to your appointment.

Insurance regulations require that we check your insurance card prior to your visit. Some insurance companies also require a referral from your primary care provider before we can see you. If you do not have your card or referral at the time of your appointment, insurance regulations require that you sign a financial waiver. All co-pays and deductibles are to be paid at the time of service. We file all insurance claims for medical services and bill you any remaining balance, which is to be paid promptly. If insurance is not responsible or available, full payment must be paid at the time of service.

We look forward to being of service to you. Shideler Dermatology Group has a 24-hour cancellation policy, so if you need to cancel your appointment, we would appreciate a 24-hour notice. If you have any questions, please feel free to call our office at **(317) 846-2396** or call toll free at **1-877-294-3100**.

Sincerely,

The Shideler Dermatology Group

755 West Carmel Drive, Suite 101

Carmel, Indiana 46032

317.846.2396 or 1.877.294.3100

Fax: 317.846.1699

E-mail: info@shideler.com

www.shideler.com

General, Cosmetic and Surgical Dermatology

Botox[®], Thermage[®], Fraxel[®], Laser Hair Removal, Sclerotherapy,

Laser Vein Removal, Photorejuvenation, Laser Skin Resurfacing,

Acne Laser Therapy, Hair Transplants, Liposuction,

Therapeutic Facial Treatments and Aesthetic Procedures

Patient: _____ Birthdate: _____ Date: _____

Chief Complaint: Acne Warts Mole Rash Eczema Growth Other - Explain: _____

How long have you had this problem? _____ Where is it on your body? _____

What symptoms do you have? _____ Are your symptoms: Mild Moderate Severe

Do you have any other symptoms? _____ What previous treatments have you used? _____

Who is your primary care physician? _____

Did a physician or health care provider refer you? _____ If so list name: _____

Are you allergic to anything? Yes No What? _____

What is your current/former occupation (grade & school if student)? _____

Women Only: Are you pregnant and/or planning pregnancy? Yes No Are your menses? reg irreg. none

List any medications that you are currently taking (include over-the-counter, vitamins, herbals, etc.).

Do you have now or have you ever had diseases or conditions of: (please check YES or NO)

Arthritis/Joint Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Artificial Joint	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bladder Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Irregular Heartbeat	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood Clots	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver/Gall Bladder Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cataracts/Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Convulsions/Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Phlebitis/ Vein Inflammation/Circulation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emotional Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Polycystic Ovaries	Yes <input type="checkbox"/>	No <input type="checkbox"/>
GI/Stomach Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	TB/Lung Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease/Attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	VD/Sexually Transmitted Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had or been exposed to HIV/ AIDS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other Medical Problems:		

List any surgical procedures:

SKIN:

Have you personally had skin cancer or pre-cancer? Yes No

Do you have a personal history of any specific skin disease? Yes No

Do you have problems with skin or wound healing? Yes No

Do you develop keloids or thick scars after surgery? Yes No

Do you bleed easily? Yes No

Are you prone to herpes (fever blister) outbreaks? Yes No

Do you actively tan your skin? Yes No

Explain:

SOCIAL:

Do you drink alcohol? Yes No

Do you use recreational drugs? Yes No

Explain:

FAMILY HISTORY: Has anyone in your family had:

Skin Cancer Eczema Psoriasis Skin Cancer Significant Acne Hay Fever Asthma

TRAVEL: Recent travel outside the United States? Yes No If so, where _____

WHAT ADDITIONAL EDUCATIONAL MATERIAL MAY WE PROVIDE FOR YOU?

<input type="checkbox"/> Botox	<input type="checkbox"/> Laser Hair Reduction	<input type="checkbox"/> Laser Facial Blood Vessel Treatment
<input type="checkbox"/> Leg Spider Vein Treatment	<input type="checkbox"/> Skin Tag /Mole Removal	<input type="checkbox"/> Restylane (filler) Injections
<input type="checkbox"/> Better Home Care Products	<input type="checkbox"/> Peels/Facial Rejuvenation	<input type="checkbox"/> Brown Spots Reduction
<input type="checkbox"/> Laser Hair Removal	<input type="checkbox"/> Light Therapy for Acne	<input type="checkbox"/> Liposuction

(Please complete using **BLACK** ink)

Patient Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-mail: _____

Shideler Dermatology will send out a quarterly newsletter dedicated to the care and health of your skin. We may also send information about new procedures. If you would like to receive this information, please list your email address

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security #: _____ Sex M / F

I authorize Shideler Dermatology Group to call and leave voicemail or a message with a family member or on my answering machine reminding me of future appointments.

Signature: _____ **Date:** _____

Responsible Party Information (Person to receive bill):

Guarantor: _____ Relationship to patient: _____

(Person Responsible for bill)

Guarantor's Address: _____ Zip Code: _____

(If different from Patient)

Guarantor's Home Phone: _____ Work Phone: _____

(If different from Patient)

Guarantor's Date of Birth: _____ Guarantor's Soc Sec #: _____

Please present insurance card to receptionist

Insurance Carrier: _____ ID#: _____ Group #: _____

Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Soc Sec # (if not ID#) _____

Employer: _____ Employer's Phone#: _____

Employer Address _____

I understand that I am financially responsible for all charges for services rendered to me, including the balance after payment of possible insurance benefits. Our staff does file all insurances for any medical services (when complete information is received). Primary and secondary carrier claim will be submitted, on my behalf. Resubmissions of claims are only done IF we must supply additional information; otherwise all appeals are patient responsibility. I authorize payment of insurance benefits to The Shideler Dermatology Group. I agree to pay for all costs involved in pursuing collection of the balance due, including court cost, attorney's fees, and collection fees. I authorize the release of any medical information necessary to process a claim to my insurance carrier.

Signature: _____ **Date:** _____

How did you hear about our office?

Yellow pages Internet Shideler.com Family/ Friend Other _____

Referring Physician Name: _____ Phone Number _____

DIRECTIONS

Traveling from U.S. 31 or Meridian Street

From the intersection of Meridian and West Carmel Drive you will
Turn east on West Carmel Drive (You will see the Meijer Store on the NE corner)
Continue on Carmel Drive approximately $\frac{3}{4}$ of a mile.
Our office is located on the south (right) side of the road in a two-story red brick building,
at the corner of Carmel Drive and City Center Drive in
“Carmel Executive Park” – Shideler Dermatology is in Suite 101

Traveling from Keystone Avenue:

Turn west onto Carmel Drive. (You will see McDonalds on the NW Corner)
Continue on Carmel Drive through the 4th stop light, which is Guilford Road.
At the 5th light you will turn left on City Center Drive.
We are in the two-story red brick building immediately on your right in
“Carmel Executive Park” – Shideler Dermatology is in Suite 101

755 West Carmel Drive, Suite 101, Carmel, IN 46032 – 317-846-2396

