DERMATOLOGY SURGICAL-MEDICAL CLINICS

PATIENT INFORMATION(Please Print)

Name____Sex: Male_____Female_____
Last First MI

Mailing Address____
Street Address City State Zip

Home Phone()_________________Work Phone ()______________ Driver's Lic.#________________________

Cell Phone ()__________________SS#_______/______/_______ Date of Birth____/____/______Age________

Occupation________________________Employer_____________________Email address_________________________

Referred by_______________________________ Primary Care Physician_____________________________________

Primary Local **PHARMACY**____

PARENT OR RESPONSIBLE PARTY **(if different from patient and if patient is an minor)**

Name____Sex: Male_____Female____
Last First MI

Address____
Street Address City State Zip

Home Phone ()_________________Work Phone ( )______________ Driver's Lic.#____________________

Cell Phone ()__________________SS#________/_____/__________ Date of Birth______/______/_______

INSURANCE INFORMATION(**Please present ins card(s) so copies may be made in addition to completing the information below)**

Primary Insurance Name______________________________Primary Insured's Name__________________________
Relationship of patient to the Insured -(circle one) Self Spouse Parent Child Other______________________

Secondary Insurance Name_____________________________Secondary's Insured's Name_______________________
Relationship of patient to the Insured -(circle one) Self Spouse Parent Child Other____________________

Do we have your permission to:

Leave a message on your answering machine at home?______Yes_______No Detail info.______or Just Phone#_______
Discuss your medical condition with any member of your household? ________Yes_______No
If yes, whom____Relationship_____________________________
Cosmetic patients do we have permission to enter you into Brilliant Distinctions Reward program? ______Yes ______No

IT IS YOUR REPONSIBILITY TO BE FAMILIAR WITH YOUR INSURANCE POLICY AND ITS COVERAGE. THIS INCLUDES HMO REFERRALS, COPAYS, OUT OF NETWORK, PPO, PLUS PLANS AND DEDUCTIBLES. COSMETIC PROCEDURES ARE NOT SUBMITTED TO INSURANCE AND ARE PAYABLE AT THE TIME OF SERVICE.

AS A COURTESY WE WILL BILL YOUR INSURANCE COMPANY, HOWEVER, YOU ARE RESPONSIBLE FOR ALL CHARGES RENDERED TO YOU THAT ARE NOT COVERED BY YOUR INSURANCE COMPANY.

THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

____Date______/______/______
Patient or Responsible Party Signature

Returned Checks

There will be a **$20.00** surcharge for all checks written and returned by our bank due to insufficient funds.

NOTICE OF PRIVACY PRACTICES- Acknowledgement

Our privacy policy is posted in the waiting room. Copy of the Privacy Practice policy is available upon request. **By my signature below I acknowledge having been offered a copy of the Notice of Privacy Practices.**

____ ________________________________
Patient or legally authorized individual signature Date

____
Printed name if signed on behalf of the patient Relationship (parent, guardian, personal Rep.)

Dermatology Medical History

Patient Name: ______________________________

Email address: ______________________________

Current Medications and Supplements **Including over the counter: Vitamins, Aspirin; etc.**

Name:____________________ Dosage:________________
Name:____________________ Dosage:________________
Name:____________________ Dosage:________________
Name:____________________ Dosage:________________
Name:____________________ Dosage:________________
Name:____________________ Dosage:________________
Name:____________________ Dosage:________________
Name:____________________ Dosage:________________

☐ **Itemized List Provided**

YES **NO**

☐ ☐ Are you allergic to any medications?

Which one(s)?

____

____

Describe your reaction:

____

☐ ☐ Rash, Nausea, Vomiting and/ or Diarrhea

☐ ☐ **Are you in good general health?**

HAVE YOU HAD

☐ ☐ Have you ever had any problems with local anesthesia?

☐ ☐ Skin cancer **(circle which one(s):**
Basal Cell Squamous Cell Melanoma

☐ ☐ Abnormal moles

☐ ☐ Precancerous spots

☐ ☐ Excessive scarring/ Keloid

☐ ☐ Skin diseases. If so, please list:

____

____

☐ ☐ Pigmentation problems

☐ ☐ Psoriasis

☐ ☐ Eczema

☐ ☐ Bleeding tendency/excessive bruising

☐ ☐ Poor wound healing

PLEASE LIST PREVIOUS SURGERIES AND DATES:

____

____

____

Patient Signature **Date**

Patient Updated: ______________________________

Patient Updated: ______________________________
Initial and date

HAVE YOU HAD:
(CIRCLE which one applies to condition below)

YES **NO**

☐ ☐ High blood pressure

☐ ☐ High Cholesterol

☐ ☐ Heart attack/disease / murmur /Angina / Heart value

☐ ☐ Pacemaker

☐ ☐ Tuberculosis

☐ ☐ Liver problems

☐ ☐ Hepatitis- A / B / C

☐ ☐ Herpes/cold sores

☐ ☐ Diabetes/High blood sugar

☐ ☐ Epilepsy-convulsions or seizures

☐ ☐ Glaucoma

☐ ☐ Eye pressure

☐ ☐ Kidney disease/bladder problems/Stones

☐ ☐ Arthritis, joint or back problems

☐ ☐ Asthma or list other respiratory problems

☐ ☐ Thyroid problems

☐ ☐ Hay fever/seasonal allergies

☐ ☐ Stroke

☐ ☐ Cancer: ____________________

☐ ☐ Prostate Problems

☐ ☐ Bowel disease/Colitis/GERD

☐ ☐ Headaches/Migraines

☐ ☐ Cataracts

☐ ☐ History of blood clots in legs or lungs

☐ ☐ Artificial joint(s) –

List______________________________

☐ ☐ Cosmetic Surgery

If yes to any above, explain:

____

____

____

Any other conditions not listed above-

List:______________________________

____

Are you?:

Pregnant? Due date: ____________

Nursing? ____________

Did you know we offer a variety of cosmetic procedures? Please circle areas of interest.

Botox, Fillers, Peels, Latisse, Leg Veins.

____

Reviewed By **Date**