



**Patient Information Form**

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

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

First MI Last

Sex M:\_\_\_ F:\_\_\_ Other:\_\_\_\_\_ DOB:\_\_\_\_\_ AGE\_\_\_\_\_

Email:\_\_\_\_\_ Needed for access to the patient portal.

Cell #:\_\_\_\_\_ Home Phone #:\_\_\_\_\_

**\*Can we leave a detailed message on voicemail? Yes: \_\_\_\_\_ No: \_\_\_\_\_**

Address \_\_\_\_\_

City State Zip Code

Mailing address \_\_\_\_\_ check if same as above

**Circle** Marital Status: Single, Married, Separated, Divorced, Widowed, Decline

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

**Circle** Ethnicity: Hispanic/Latino, Not Hispanic/Latino, Other: \_\_\_\_\_, Decline

**Circle** Race: American Indian or Alaska Native White, Black, Asian, Decline

Reason for this visit: \_\_\_\_\_

Have you been seen in our office previously? No, Yes Last Visit: \_\_\_\_\_

How did you hear of our office? \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Circle** Status: Part-time, Full-time, Self-Employed, Retired, Active Military, Student, Unemployed

Person responsible for payment: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**\*Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_**

Phone: \_\_\_\_\_.

I do give my consent and permission to share and discuss my medical information, history,

tests, and labs with \_\_\_\_\_. Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_.

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**PHARMACY** If you do not have a regular pharmacy, please choose the most convenient (i.e. a location at which you regularly shop) for any prescription which may be sent during your upcoming visit.

Name, Address or Cross Streets: \_\_\_\_\_

Phone #: \_\_\_\_\_ Mail Order: \_\_\_\_\_

### **CARE TEAM**

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Another, Specialist Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Patients 65+:**

Advanced Directive: Do you have one of the following?

\_\_\_ Power of Attorney (Surrogate Decision Maker) \_\_\_ Living Will (Advance Care Plan)

\_\_\_ None

Name/Relationship \_\_\_\_\_

Have you received a Pneumonia Vaccine? No Yes

### **PATIENT QUESTIONNAIRE**

Have you ever been diagnosed with ***Melanoma***? No Yes Locations: \_\_\_\_\_

When, Details: \_\_\_\_\_

Do you or have you used a **tanning** bed? No, Yes, Currently, Past: \_\_\_\_\_

Do you have a **history of blistering sunburn**? No Yes How Often \_\_\_\_\_

Do you wear **sunscreen**? No Yes What SPF \_\_\_\_\_ How often? \_\_\_\_\_

Do you have any **immediate family members with skin cancer**? No \_\_\_ Yes \_\_\_

Which family member(s) and what type of skin cancer, if known, i.e. Basal Cell Carcinoma, Squamous Cell Carcinoma, Malignant Melanoma, or uncertain?

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

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### **Authorization and Release (Please READ AND INITIAL each line and sign at the bottom)**

1. Initial\_\_\_\_\_ I hereby acknowledge receipt of Aesthetic Surgery & Dermatology's Notice of Privacy Practices.
2. Initial\_\_\_\_\_ Late/Cancellation/No Show policy: To better serve our patients, we ask that if you are going to be more than 10 minutes late, please call use to ensure that we can still work you into our schedule. If you need to cancel or reschedule an appointment, we ask that you call 24 hours prior to your appointment. Failure to cancel or reschedule for a surgery or procedure 24 hours or more prior to appointment, you will be charged.
3. Initial\_\_\_\_\_ I am responsible for payment in full at time of service unless previous arrangements have been made.
4. Initial\_\_\_\_\_ I hereby authorize the release of medical information to my insurance carrier that may be necessary to process my claim, and to any other facility or Doctor involved in my care.
5. Initial\_\_\_\_\_ I hereby authorize payment directly to Aesthetic Surgery & Dermatology for my medical expenses.
6. Initial\_\_\_\_\_ In the event it is necessary to refer this account to collections, I/we agree to pay all costs of collection including but not limited to reasonable attorney fees, court costs and interest permitted by law.
7. Initial\_\_\_\_\_ If my insurance company denies payment, I agree to be personally and fully responsible for any of the remaining balance. I authorize Aesthetic Surgery and Dermatology to charge my credit card I may have on file for these balances.
8. Initial\_\_\_\_\_ I authorize this facility to contact the patient, or authorized representative or guardian with any necessary medical information through telephone, fax or other communication.
9. Initial\_\_\_\_\_ I have read and understand the above information. I also verify that the information is correct.

I hereby verify above information above is accurate and complete.

X\_\_\_\_\_   
Signature of Patient, Parent / Guardian, or Personal Representative

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever been screened for **Hepatitis C?** Yes or No

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**MEDICATIONS:** Please list any/all medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication, including recreational). If None, write "None"

Medication:                      Dose:                      Frequency:                      For What condition(s)?

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies:** List all allergies, including latex, seasonal, medical, food, environmental. Include your reactions. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you use **tobacco products**? *No, Never Former Yes* : how many packs / day? \_\_\_\_\_

Former Smoker: Quit date: \_\_\_\_\_ Years: \_\_\_\_\_ Packs/day: \_\_\_\_\_

Snuff: \_\_\_\_\_ Chew \_\_\_\_\_

Have you received a **Flu Vaccine** this past year? *No Yes*

Do you **drink alcohol**? *No Yes* How many drinks per day/month? \_\_\_\_\_

\*In the past year have you had **5 or more drinks in a day for men?** or **4 or more drinks in a day for women?** Please Circle: *Never Once Twice Three Occasions Four or More* \_\_\_\_\_.

Substance Abuse? Circle: *Never, Former, Yes*, How Often: \_\_\_\_\_

Current Type: \_\_\_\_\_

**\*ALERTS:** Check all that apply.

<input type="checkbox"/>	Pregnancy or Planning a Pregnancy?	<input type="checkbox"/>	Cold Sores or History of HSV
<input type="checkbox"/>	Currently Breast Feeding?	<input type="checkbox"/>	MRSA
<input type="checkbox"/>	Adhesive Allergy	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	Topical Antibiotic Ointment Allergy	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	Lidocaine Allergy	<input type="checkbox"/>	HIV Positive
<input type="checkbox"/>	Rapid Heartbeat with Epinephrine	<input type="checkbox"/>	West African Travel or Contact
<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Ebola Risk: Fever>100.4° F / 38.0° C
<input type="checkbox"/>	Artificial Joints within last 2 years	<input type="checkbox"/>	Ebola Risk: Resided or Traveled to Country with wide-spread Ebola Transmission in last 21 days
<input type="checkbox"/>	Defibrillator	<input type="checkbox"/>	Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Blood Thinners
<input type="checkbox"/>	Premedication prior to procedures	<input type="checkbox"/>	Fainting with injections

**Additional Alerts:**

\_\_\_\_\_

\_\_\_\_\_

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## Your Medical History Check and List all that Apply

<input type="checkbox"/> Allergies or Hay Fever <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Autoimmune Disorder <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Blood Clots <input type="checkbox"/> Depression / Anxiety <input type="checkbox"/> Diabetes - Type 1 or Type 2? <input type="checkbox"/> Difficulty healing / keloids <input type="checkbox"/> Eczema <input type="checkbox"/> Exposure to someone with Tuberculosis/TB <input type="checkbox"/> Hearing loss <input type="checkbox"/> Heart attack / Stroke / CAD <input type="checkbox"/> Heart disease, failure, or irregular heart <input type="checkbox"/> Hepatitis Which type? <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cancer or history of: Which/Where <input type="checkbox"/> History of positive blood transfusion(s) <input type="checkbox"/> History of positive PPD or Tuberculosis, TB <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Hives <input type="checkbox"/> Immune suppression, including transplant patient <input type="checkbox"/> Irregular menstruation of PCOS <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Problems <input type="checkbox"/> Lung Disorder, including COPD <input type="checkbox"/> Migraines / Headaches <input type="checkbox"/> Neurological Disorder, i.e. seizure <input type="checkbox"/> Psoriasis <input type="checkbox"/> Thyroid Problems-Hyper/Hypo circle one <input type="checkbox"/>
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List any other medical/skin problems: \_\_\_\_\_

Past *Surgeries* (include date of surgery):

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Please check if you have the following as related to your current situation – 1<sup>st</sup> of 2 pages

<input type="checkbox"/> Constitutional/Symptom <input type="checkbox"/> fever or chills <input type="checkbox"/> night sweats <input type="checkbox"/> unintentional weight loss <input type="checkbox"/> unintentional weight gain <input type="checkbox"/> fatigue	<input type="checkbox"/> Psychiatric <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> mood swings/changes in mood <input type="checkbox"/> suicidal thoughts or acts <input type="checkbox"/> homicidal thoughts or acts <input type="checkbox"/> other psychiatric
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<b>Skin/Integumentary</b> new or changing moles changing skin lesion(s) rash(es) skin itching skin or lip dryness sun sensitivity hair changes nail changes problems with healing problems with scarring (hypertrophic)	<b>Gastrointestinal (G.I.)</b> difficulty swallowing heartburn nausea and/or vomiting constipation and/or diarrhea bloody stool abdominal pain
<b>Eyes</b> loss of vision blurred or distorted vision vision haloes decreased or impaired night vision eye pain or soreness dry eyes	<b>Genitourinary (G.U.)</b> urinary frequency pain with urination blood in urine breast mass(es) or discharge
<b>ENT/Mouth</b> dizziness ringing in ears loss of hearing sinus congestion runny nose/post nasal drip nose bleeds sore throat hoarseness or throat/mouth dryness dental health problems	<b>G.U. Male Only</b> penile discharge
<b>Cardiovascular</b> chest pain heart palpitations (irregular beating or heart skips a beat) cardiovascular other	<b>G.U. Female Only</b> vaginal bleeding or discharge pelvic pain [female only] irregular menstruation
	<b>Musculoskeletal</b> joint pain, swelling, redness muscle pain, aches or cramps neck stiffness
	<b>Endocrine</b> heat or cold intolerance excessive thirst or hunger other thyroid problems
	<b>Hematologic/Lymphatic</b> problems with bruising problems with bleeding swollen lymph nodes
	<b>Neurological</b> headaches, including migraines numbness or tingling slurred speech weakness or paralysis fainting or blackouts seizures

Return when finished.