Patient Information Form

Date: ____________________

Name: ____ Preferred Name: ____________________
First MI Last

Sex: *circle* M or F Other: __________ DOB: ______________ AGE ______

Email: ____ Needed for access to the patient portal.

Cell #: ______________________________ Home Phone #: ____________________________

*Can we leave a detailed message on voicemail? *circle* *Yes* or *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 <u>do</u> 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: ____________________

PATIENT QUESTIONAIRE

Have you ever been diagnosed with skin cancer (Basal Cell or Squamous Cell Carcinoma)?

circle No or Yes Location(s): ______________________________

When was it removed?: ______________________________

Have you ever been diagnosed with *Melanoma*? *circle No or Yes*

Location(s): ____________________ When was it removed?: ____________________

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

Do you have a history of blistering sunburn? *No Yes* How many? ____________________

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______ We impose a surcharge on credit cards that is not greater than our cost of acceptance for non medical charges.
10. 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____ Date:____________________

Signature of Patient, Parent / Guardian, or Personal Representative

If Parent/Guardian or Personal Representative, what is your relationship to patient: ________________

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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.____________________________________

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____

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.

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

Additional Alerts:

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Your Medical History Check and List all that Apply

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

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 – 1st of 2 pages

	Constitutional/Symptom		**Psychiatric**
___	fever or chills	___	anxiety
___	night sweats	___	depression
___	unintentional weight loss	___	mood swings/changes in mood
___	unintentional weight gain	___	suicidal thoughts or acts
___	fatigue	___	homicidal thoughts or acts
		___	other psychiatric

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	Skin/Integumentary
___	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)
	Eyes
___	loss of vision
___	blurred or distorted vision
___	vision haloes
___	decreased or impaired night vision
___	eye pain or soreness
___	dry eyes
	ENT/Mouth
___	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
	Cardiovascular
___	chest pain
___	heart palpitations (irregular beating or heart skips a beat)
___	cardiovascular other
	Gastrointestinal (G.I.)
___	difficulty swallowing
___	heartburn
___	nausea and/or vomiting
___	constipation and/or diarrhea
___	bloody stool
___	abdominal pain
	Genitourinary (G.U.)
___	urinary frequency
___	pain with urination
___	blood in urine
___	breast mass(es) or discharge
	G.U. Male Only
___	penile discharge
	G.U. Female Only
___	vaginal bleeding or discharge
___	pelvic pain [female only]
___	irregular menstruation
	Musculoskeletal
___	joint pain, swelling, redness
___	muscle pain, aches or cramps
___	neck stiffness
	Endocrine
___	heat or cold intolerance
___	excessive thirst or hunger
___	other thyroid problems
___	Hematologic/Lymphatic
___	problems with bruising
___	problems with bleeding
___	swollen lymph nodes
	Neurological
___	headaches, including migraines
___	numbness or tingling
___	slurred speech
___	weakness or paralysis
___	fainting or blackouts
___	seizures

Return when finished.