



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 do give my consent and permission to share and discuss my medical information, history, tests, and labs with _____ Phone: _____

Relationship: _____

ALL PAGES ARE FRONT AND BACK

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 QUESTIONNAIRE

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?

ALL PAGES ARE FRONT AND BACK

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 _____
Signature of Patient, Parent / Guardian, or Personal Representative

Date: _____

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

ALL PAGES ARE FRONT AND BACK

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.

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:

ALL PAGES ARE FRONT AND BACK

Your Medical History Check and List all that Apply

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

List any other medical/skin problems: _____

Past Surgeries (include date of surgery): _____

Please check if you have the following as related to your current situation -- 1st of 2 pages

<input type="checkbox"/> Constitutional/Symptom	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> fever or chills	<input type="checkbox"/> anxiety
<input type="checkbox"/> night sweats	<input type="checkbox"/> depression
<input type="checkbox"/> unintentional weight loss	<input type="checkbox"/> mood swings/changes in mood
<input type="checkbox"/> unintentional weight gain	<input type="checkbox"/> suicidal thoughts or acts
<input type="checkbox"/> fatigue	<input type="checkbox"/> homicidal thoughts or acts
	<input type="checkbox"/> other psychiatric

ALL PAGES ARE FRONT AND BACK

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

Return when finished.