

PATIENT INFORMATION

Name: _____

Last

First

M.I.

Address: _____

Street

City

State

Zip

SS#: _____ Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Cell Phone: (____) _____ **Email address for Newsletter:** _____

Date of Birth: ____/____/____ Age: ____ Gender: M F Marital Status: S M D W

Employer: _____ Occupation: _____

Name of spouse, parents, or guardian (circle one): _____

RESPONSIBLE PARTY (Insurance subscriber information-must be filled in)

Name: _____

Last

First

M.I.

Address: _____

Street

City

State

Zip

Work Phone: (____) _____ Ext. _____ Home Phone: (____) _____

Cell Phone: (____) _____ E-Mail Address: _____

SS#: _____ Date of birth: ____/____/____ Relationship to patient: _____

I hereby authorize Dr. Street or her assistants to treat my child in my absence. _____

Parent Signature

INSURANCE INFORMATION (Please present card at time of check-in.)

Primary insurance name: _____ **Secondary** insurance name: _____

Policy holder: _____ Policy Holder: _____

Contract #: _____ Contract #: _____

Group #: _____ Group #: _____

Relationship to patient: _____ Relationship to patient: _____

Other family members that are patients: _____

Pharmacy of choice: _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

Relationship

Who is your family doctor? _____ Phone: _____

How did you hear about our office? _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this provider for any services furnished me by this physician. I authorize any medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine benefits for related medical services. I authorize Medicare to furnish the above-named doctor any information regarding my medical claims under Title XVII of the Social Security Act.

Commercial Insurance

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the doctor indicated on the claim. I understand I am financially responsible for any balance not covered by insurance. I give consent for Dr. Street to communicate with my referring physician.

Signature: _____ Date: ____/____/____

A copy of this signature is valid as original

Revised 8/07 lkp

MEDICAL HISTORY--Part 1

Name: _____ Date of birth: _____

Why are you here today and when did the problem begin? _____

Please list any previous skin conditions: _____

Have you had skin cancer? _____ What type(s) and where was it located? _____

Has anyone in your family had skin cancer? _____ Their relationship to you and type(s) of skin cancer: _____

Please list any known **reactions, sensitivities, or allergies to drugs, foods, or plants:** _____

Please list all medications/drugs you have taken in the last few weeks including vitamins, drops, laxatives, suppositories, pills, aspirin, Tylenol, injections, marijuana, cocaine, tranquilizers, amphetamines, birth control pills, etc.: _____

Please list all medications you take or apply **regularly:** _____

Do you use: Tobacco_____ Caffeine_____ Alcohol_____ Substance Abuse_____
_____pks/day _____cups/day _____glasses/day type:_____

Do you have any artificial heart valves? Please explain: _____

Do you have any artificial joints? Please explain: _____

DO YOU HAVE A PACEMAKER OR OTHER TYPE OF IMPLANTED DEVICE TO REGULATE YOUR HEARTBEAT? _____

If yes, what type? _____

Do you have a mitral valve prolapsed ? _____

DO YOU NEED TO TAKE ANTIBIOTICS BEFORE ANY SURGERIES OR DENTAL PROCEDURES? _____

I consent to being tested for hepatitis/HIV(AIDS) if an office staff member is directly exposed to potentially contagious material (i.e., needle stick).

Please list your surgical history:

Surgery: _____ Year: _____ Surgery: _____ Year: _____
Surgery: _____ Year: _____ Surgery: _____ Year: _____
Surgery: _____ Year: _____ Surgery: _____ Year: _____
Surgery: _____ Year: _____ Surgery: _____ Year: _____

Patient Name: _____ DOB: _____ HEIGHT: _____ WEIGHT: _____

MEDICAL HISTORY FORM PART 2--REVIEW OF SYSTEMS

System Review	Circle all that apply (Presently)	Yes	No	Comments
Musculoskeletal	Arthritis, weakness, back pain, joint pain, cramps, stiffness			
Neurologic	Seizures, stroke, balance changes, numbness/tingling, headaches, dizziness, migraines			
Constitutional	Fevers, night sweats, chills			
Eyes	Visual loss or change, trauma, contacts, cataracts, blurred vision, glaucoma			
Ears, Nose, Throat	Loss of hearing, trouble swallowing, nosebleeds, hoarseness, earache, nasal polyps			
Respiratory	Shortness of breath, asthma, difficulty breathing, emphysema, bronchitis, tuberculosis			
Cardiovascular	Heart attack, irregular heartbeat, heart murmur, chest pain, high blood pressure			
Gastrointestinal	Ulcer, hepatitis, weight changes, bowel changes, weight gain, weight loss, liver problems, intestinal disorders			
Genitourinary	Painful urination, difficulty urinating, blood in urine, renal disease/failure, frequent urination, kidney problems			
Hematologic	Blood clots, anemia, bleeding problems, hepatitis, blood transfusions			
Endocrinology	Tolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue			
Psychological	Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression, mental disorders, nervousness			
Skin	Color changes, infections, masses, open sores, hair changes, rash, itching, eczema			
Immunologic/Allergic	Dermatitis, latex allergy, hives, rash, asthma, hay fever, diabetes			
Other Health Problems	Cancers, infectious disease, HIV, autoimmune disease, etc.			

Patient/Guardian Signature _____ Date _____

Medical History Form Parts 1 and 2 reviewed by:

Provider Signature _____ Date _____ Provider Signature _____ Date _____
 Provider Signature _____ Date _____ Provider Signature _____ Date _____
 Provider Signature _____ Date _____ Provider Signature _____ Date _____
 Provider Signature _____ Date _____ Provider Signature _____ Date _____
 Provider Signature _____ Date _____ Provider Signature _____ Date _____
 Provider Signature _____ Date _____ Provider Signature _____ Date _____

COSMETIC INTEREST QUESTIONNAIRE

General appearance topics or products of interest to you. Please check all that apply.

<ul style="list-style-type: none"> <input type="checkbox"/> Med Spa Information <input type="checkbox"/> Skin Care Advice <input type="checkbox"/> Acne Prevention <input type="checkbox"/> Facial Fine Lines <input type="checkbox"/> Facial Wrinkles <input type="checkbox"/> Facial Folds <input type="checkbox"/> Brown Spots/Age Spots <input type="checkbox"/> Facial Spider Veins <input type="checkbox"/> Facial Redness <input type="checkbox"/> Leg Veins <input type="checkbox"/> BOTOX® 	<ul style="list-style-type: none"> <input type="checkbox"/> Skin & Hair Care Products <input type="checkbox"/> Anti-Aging Products <input type="checkbox"/> Laser Hair Removal <input type="checkbox"/> Permanent Cosmetics <input type="checkbox"/> Eyelash Extensions <input type="checkbox"/> Skin Tightening—Face, Neck <input type="checkbox"/> Body Contouring <input type="checkbox"/> Tooth Whitening <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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Are you interested in meeting with our cosmetic consultant in order to create a personal treatment plan designed to meet your cosmetic needs? (There is no charge to our clinic patients for this consultation.)

- Yes No thanks

For Office Use Only

Date: _____ Initials: _____



Doctor's Approach™
Dermatology & Laser Center

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GUARANTEE OF PAYMENT FOR SERVICES

In the interest of providing you with uninterrupted quality medical care, we are advising you of the following:

As the patient, it is your responsibility to know the extent of your insurance benefits and to be aware of the amount of your co-pay which is due at the time of service.

If for any reason your insurance company chooses not to cover your office visit or any procedures, **you will be responsible for payment at the time of service.** The cost for a visit can be provided to you in advance.

Your signature below indicates that you will be responsible for payment in full should your insurance company choose not to pay for a visit or procedure.

We also request you provide 24-hour notice for appointment cancellations. **Please note that your signature also indicates that you take responsibility for a \$50.00 fee for all no-show appointments.** Patients with 2 no-show appointments may be dismissed.

I, _____, have read and agree with the above statement and further agree to be responsible for all charges incurred.

Signature: _____ Date: _____