Intake and History Form

Name: ______________________________ Date: ______________

Street Address: ______________________________ City / State: ______________________________

Zip Code: ______________ Date of Birth: ______________ Gender: ☐ Male ☐ Female

Social Security Number:______________ Marital Status:______________

Spouse Name:______________ Spouse Phone Number:______________

Caretaker Name:______________ Caretaker Phone Number:______________

If **Minor Child**, List name of Parent(s) or Guardian(s):

Name:______________ Relationship:______________ Phone:______________

Name:______________ Relationship:______________ Phone:______________

Home: ______________ Work: ______________ Cell:______________

OK to Leave Detailed Message ☐ YES ☐ NO May we send general and/or cosmetic information via email ☐ YES ☐ NO

Preferred Method of Contact ☐ Home Phone ☐ Cell Phone ☐Work Phone ☐ Email

Email Address: ______________________________

Language:______________ Race: ______________ Ethnic Group: ☐ Hispanic ☐Non-Hispanic

How did you hear about us? ☐ Referred by______________ ☐ Internet ☐ Phone Book

Emergency Contact

Name:______________ Relationship:______________ Phone:______________

Employment Information

Employer Name:______________ Occupation:______________

Preferred Pharmacy

Name: ______________

Street/Cross Street:______________ City or Zip Code: ______________

Phone Number: ______________

Primary Insurance Information

Primary Insurance Company:______________ Policy Holder:______________

Relationship To the Patient:______________ Date of Birth of Policy Holder:______________

Secondary Insurance Information

Primary Insurance Company:______________ Policy Holder:______________

Relationship To the Patient:______________ Date of Birth of Policy Holder:______________

Intake and History Form

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
  Type:____________________
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Cancer
  Type:____________________
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
  Type_____________________
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Liver Disease
  Type_____________________
- ☐ Lung Disease
  Type_____________________
- ☐ Neuromuscular Disease
  Type_____________________
- ☐ Renal Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
  Type_____________________
- ☐ Other
  ____
- ☐ None

Past Surgical History

Have you had any surgeries on the following organs? If yes, what year?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Cesarean Section
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy
- ☐ Other:_______________________________________
  ____
- ☐ None

Intake and History Form

Skin Disease History

Have you had any of the following?

☐ Abnormal Moles

☐ Actinic Keratoses

☐ Basal Cell Skin Cancer
Site/Year__________________________________

☐ Dry Skin

☐ Eczema

☐ Flaking or Itchy Scalp

☐ Melanoma
Lymph Node Involvement: □YES □NO
Site/Year__________________________________

☐ Squamous Cell Skin Cancer
Site/Year__________________________________

☐ Other

____

____

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

☐ Mother

☐ Father

☐ Sister

☐ Brother

☐ Daughter

☐ Son

☐ Uncle

☐ Aunt

☐ Nephew

☐ Niece

☐ Grandmother

☐ Grandfather

☐ Grandson

☐ Granddaughter

☐ Other

Intake and History Form

Smoking Status (please choose one):

- ☐ Current smoker
- ☐ Former smoker
- ☐ Never smoker

Alcohol Intake (please choose one):

- ☐ None
- ☐ Daily
- ☐ Social

____

Alerts

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointment
- ☐ Artificial heart valve
- ☐ MRSA
- ☐ Pregnant or planning pregnancy
- ☐ Premedication for procedures
- ☐ Rapid heart rate with epinephrine

Intake and History Form

Height and Weight

Height:______________________________ Weight:______________________

Medications ☐NONE Do we have permission to import your medications? ☐YES ☐NO

List all current medications and dosage if known:

____

____

____

Allergies ☐No Known Drug Allergies

List all allergies and reactions if known:

____

____

____

All Insurance Patients - Signature on File

I request that payment of authorized benefits from my insurance company to be made on my behalf to the Dermatology & Aesthetic Institute, the provider for services rendered to me. I authorize the release of any medical information about me to be released to the above listed insurance companies and their agents/affiliates to determine benefits payable for services rendered. I understand that the Dermatology & Aesthetic Institute / provider agrees to accept the charge allowable determined from the above listed insurance carrier(s) as a full charge, and the patient is responsible only for their copay, deductilble, co-insurance, and all non-covered services. Payment for copay, deductible, co-insurance and all non-covered services are due at the time of service.

Beneficiary Signature:____ Date:________________________

Medicare Patients - Medicare Signature on File

I request that payment of authorized Medicare benefits to be made on my behalf to the Dermatology & Aesthetic Institute/ the provider for services rendered to me. I authorize the release of any medical medical information about me to be released to the Health Care Financial Administration and their agents/affiliates to determine benefits payable for services rendered.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge allowable determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:____ Date:________________________