PATIENT HISTORY

List all medications including aspirin, topical meds, oral contraceptives, etc.________________________________

____

List all allergies to medicines, food or other? ____

Do you smoke? Y or N Do you drink alcohol? Y or N

Do you or your family have a history of melanoma or skin cancer? Y or N

If YES, please explain:____

What is the reason for your visit today? ____

MEDICAL CONDITIONS

Circle any of the following medical conditions or treatments that you have had:

Currently Pregnant	Anemia	HIV Positive	Vascular Disease	Hepatitis
High Blood Pressure	Asthma	Raynaud's	Psoriasis	Seizures
Heart Attack	Emphysema	Eczema	Anorexia	Lupus or (+) ANA
High Cholesterol	Palpitations	Collagen Injections	Reaction to Anesthesia	Depression
Diabetes	Chest Pain	Silicone Injections	Guillian-Barre	Cosmetic Surgery
Urinary Retention	Stroke	Visual Problems	Skin Cancer	Arthritis
Vasculitis	Cancer	Sickle Cell Disease	Abnormal Heart Rhythms	Dysplastic Moles
Bleeding Disorder	Cataracts	Glaucoma	Mitral Valve	Prolapse Tuberculoses

Others: ____

Do you need a letter sent to your primary physician regarding this visit? Y or N Name____________________

Address__________________________City__________________State_______Zip________

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. All charges for services are due when billed. In the event any charge becomes more than thirty (30) days overdue interest shall be added to the unpaid charge at one and one half (1.5%) percent per month. If the unpaid charges are referred to an attorney for collections I will also be responsible for collection and attorney fees equal to fifteen (15%) percent of the entire amount due. Cosmetic procedures are not covered by insurance and will be paid prior to the procedure unless otherwise approved by the office manager. Medicare does not cover cosmetic procedures or visits. It is my responsibility to obtain referrals for all my visits. This office hold no responsibility if I needed a referral and did not obtain one. I will pay the bill in full myself if I did not get a referral for the date of service and I needed one.

SIGNATURE (PATIENT OR PARENT) _________________________________DATE______________________

Assignment of Benefits: I authorize payment of medical benefits to the provider for professional services rendered

SIGNATURE (PATIENT OR PARENT) _________________________________DATE______________________

Release of information: I authorize release of any medical information necessary to process this claims

SIGNATURE (PATIENT OR PARENT) _________________________________DATE______________________

How will you be paying for today's visit? (CIRCLE) CASH CHECK CREDIT CARD

How did you hear about our office?

FRIEND__________AD__________MAGAZINE________YELLOWPAGES_________INTERNET________