

**Dermatology Laser Center & Spa**

Date: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status: S M W D

<b>If under age 18:</b>				
_____ SS# _____ DOB: ____/____/____				
<b>Parent/Guardian</b>				
_____				
Address	City	State	Zip	Drivers License

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_

Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_

For cosmetic specials via e-mail, please provide address: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred by: \_\_\_\_\_

Person to Contact in case of emergency:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**General Health History**

**Medical Problems:**

**Surgeries:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Medications:**

**Skin Problems:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Continued on Back

**Review Of Systems:**

**If yes, Please Explain**

Eye Disease	Yes	No	_____
Impaired Hearing	Yes	No	_____
Diabetes	Yes	No	_____
Immunosuppressed	Yes	No	_____
Thyroid Problems	Yes	No	_____
Asthma/Wheezing	Yes	No	_____
Pacemaker/Defibrillator	Yes	No	_____
Mitral Valve Prolapse	Yes	No	_____
Other Heart Problems	Yes	No	_____
Swelling Hands/Feet	Yes	No	_____
Liver Trouble	Yes	No	_____
Kidney Trouble	Yes	No	_____
Daily Aspirin / Blood Thinner	Yes	No	_____
Develops Thick Scars/Keloids	Yes	No	_____
Develops rash from:			
Tape	Yes	No	_____
Antibiotic creams	Yes	No	_____
<b>FEMALES: Pregnant</b>	Yes	No	_____
<b>Planning Pregnancy</b>	Yes	No	_____

*Do you give our office permission to discuss your medical/ billing information with a family member?*  
 YES       NO      If yes, please provide their name and phone number below:

Name	Relationship	Phone #
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**Primary Insurance** \_\_\_\_\_ Policy Holder Name & DOB

**Secondary Insurance** \_\_\_\_\_ Policy Holder Name & DOB

**Tertiary Insurance** \_\_\_\_\_ Policy Holder Name & DOB

Payment is expected at the time of service, method of payment today:  
 Check one: Check \_\_\_\_\_ Cash \_\_\_\_\_ Mastercard/Visa \_\_\_\_\_

I understand that I am financially responsible for all charges. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. If I have insurance, I am still financially responsible if the claim is denied or not paid in a timely manner for any reason including but not limited to pre-existing exclusions, coverage termination, or failure to secure proper authorization. It is my responsibility to inform the staff of ANY changes in insurance coverage. Should my account become a collection problem additional charges may be added.

I hereby assign all medical benefits to which I am entitled, including Medicare, Private insurance and other health plans to The Dermatology & Skin Laser Center aka Dermatology Laser Center & Spa. Further, I hereby authorize the Dermatology Laser Center and Spa to release all information necessary to secure payment.

I have had the opportunity to review the Dermatology Laser Center & Spa's Notice of Privacy Practices. I may request a copy to keep if desired.

\_\_\_\_\_  
 Signature of Patient/Legal Guardian

\_\_\_\_\_  
 Date