DERBY DERM

PATIENT INFORMATION

This is a confidential record and will be kept in your chart only.

Information will not be released without your authorization.

Today's Date: ____/_____/_____ Name: _____

E-mail: _____ Birth Date: _____/_____/_____

Address: _____ City/State _____ Zip _____

Home Phone ( ) _____-_____ Cell ( ) _____-_____ Alt ( ) _____-_____

To receive text appointment confirmations and reminders on your cell please provide the name of your

carrier such as Verizon, AT&T, Sprint, T-Mobile… _____ Preferred method of contact _____

Occupation: _____ Employer/School: _____ Circle: Male/Female

Employed/Full-time Student/Part-time Student SSN __ __ __ - __ __ - __ __ __ __

How did you hear of us? Friend/ Family, Newspaper, Internet, Billboard, Dr. Referral, Best of KS, Insurance Co, TV

If filing insurance: Policy holder (if not patient) _____ SSN __ __ __ - __ __ - __ __ __ __

Policy holder's date of birth _____ / _____/ _____ Policy holder's Phone: ( ) _____-_____

Policy holder's Address: _____ City/State: _____ Zip _____

Policy holder's Relatinship to patient: _____ Reason for visit: _____

GENE RAL MEDICAL HISTORY

Within the last year, have you been under a provider's care? No _____ Yes _____

Within the last year, have you been under a dermatologist care? No _____ Yes _____

Within the last year, have you undergone any surgery? No _____ Yes _____

If yes to any of the above please specify _____

Have you had any of these health problems in the past or present? (circle all that apply)

Asthma Arthritis Autoimmune disorder High Cholesterol

Blood Disorder Chest Pain Clotting Disorder Thyroid Disorder

Colon Problems Diabetes Depression Digestive Problems

Easy Bruising Excessie Scarring Excessive Bleeding Heart Attack

Heart Disease High Blood Pressure Hepatitis HIV / AIDS

Hormone Imbalance Irregular Heart Beat Intestional Problems Kidney Disease

Liver Disease Lung Disease Mental Disorder Multiple Slerosis

Muscular Dystrophy Mitral Valve Prolapse Migraines Neuromuscular Disease

Pheumatic Fever Shortness of Breath Seizures Stroke

If you have a history of high blood pressure, what is your typical pressure? _____ / _____

If you have a history of diabetes, are you insulin dependent? Yes _____ No _____

Are you allergic to Latex? Yes _____ No _____ Do you wear contact lenses? Yes _____ No _____

Social History: Do you smoke or use any form of tobacco? Yes _____ No _____

Allergies: (list meds and reaction.)

_____

_____
_____

List your current medications: (prescribed / OTC / herbals / supplements):
_____

_____
_____

Are you currently using any blood thinners? (Aspirin, NSAIDS, Coumadin, Plavix...) Yes _____ No _____

PAST COSMETIC HISTORY

Please place an 'X' in front of any prior cosmetic procedures:

____Chemical Peels ____Laser Resurfacing ____Botox

____Laser Hair Reduction ____ Laser Vein Treatment _____Intesnse Pulse Light Rejunation

____Microdermabrasion ____Sclerotherapy ____Fillers (Collagen, Restylane, Radiesse)

Have you had any reaction to the following? (Circle all that apply)

Cosmetics Medicine Iodine Pollen Food Animals Fragrances

Sunscreens Rubbing Alcohol Soy Lidocaine Ephiepherine Paper-Tape Hydroxy acids

The information on this form is correct to the best of my knowledge. With my consent, Derby Derm may use and disclose Protected Health Information about me to carry out Treatment, Payment and Healthcare Operations. Please ask to see the Notice of Privacy Practices (HIPPA) for a more complete description of such uses and disclosures. With this consent, Derby Derm may call or send information to carry out Treatment, Payment and Healthcare Operations, such as appointment reminders, insurance items pertaining to my clinical care, including laboratory results. If a referral is needed it is my responsibility to obtain it prior to my visit. I understand that medically necessary services may be reimbursed by insurance but aesthetic services are generally not and all costs are my responsibility.

Patient (or Guardian) Signature _____

Cancellations At Derby Derm your appointment is scheduled with a professional, whose time is allocated exclusively for your scheduled treatment. Appointments cancelled or rescheduled within 24 hours of the scheduled time will be charged a cancellation fee of $25 by credit card or invoice. If you need to cancel or reschedule an appointment, you must notify Derby Derm at least 24 hours prior to your appointment. For your convenience you may now schedule or reschedule appointment through our website, please visit DerbyDerm.com. By signing below you agree to our cancellation policy and agree to allow us to charge your credit card on file or be invoiced for such charges.

Patient (or Guardian) Signature _____