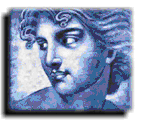
**

**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, ATT, 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, Phone Book, Billboard, Dr. Referral, Best of KS, Insurance Co, TV, Facebook

If filing insurance: Policy holder (**if different from patient**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_ \_\_ \_\_ - \_\_ \_\_ -\_\_ \_\_ \_\_ \_\_

Policy holder’s date of birth \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ Policy holder’s Phone: ( ) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL 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 Excessive Scarring Excessive Bleeding Heart Attack

Heart Disease High Blood Pressure Hepatitis HIV / AIDS

Hormone Imbalance Irregular Heart Beat Intestinal Problems Kidney Disease

Liver Disease Lung Disease Mental Disorder Multiple Sclerosis

Muscular Dystrophy Mitral Valve Prolapse Migraines Neuromuscular Disease

Rheumatic 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? \_\_\_\_\_\_

**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.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List your current medications**: (prescribed / OTC / herbals / supplements): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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/Dysport

\_\_\_\_\_Laser Hair Reduction \_\_\_\_\_Laser Vein Treatment \_\_\_\_\_ Intense Pulse Light Rejuvenation

\_\_\_\_\_Microdermabrasion \_\_\_\_\_Sclerotherapy \_\_\_\_\_Fillers (Collagen, Restylane, Radiesse)

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

Cosmetics Medicine Iodine Pollen Food Animals Fragrance Sunscreens Rubbing Alcohol Soy Lidocaine Epinephrine 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. I agree to permit Derby Derm and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account. If a referral is needed it is my responsibility to obtain it prior to my visit. All copays are due at time of appointment. I understand that if I have an office copay, Derby Derm may accept my copay as payment in full and not go through insurance. I understand that medically necessary services may be reimbursed by insurance but I may be responsible for the full or partial amount depending on my copay and deductibles. I am responsible for any remaining balance that insurance does not pay. Aesthetic services are generally not covered and all costs are my responsibility.**

**Patient (or Guardian) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**