NEW PATIENT MEDICAL DATA

Edgebrook Dermatology — Medical, Laser & Aesthetic Center

Date: _____

SSN: _____-____-_____

Mr. / Mrs. / Ms.

Patient Name: _____ DOB: ____/____/____ M ___ F ___
First Last Middle Initial

Street Address: _____ City: _____ State/Zip: _____

Phone Number: _____ Email: _____
Cell Work Home

CONTACT INFORMATION

Marital Status: _____ Is it okay for us to leave detailed voicemails on your phone if needed? Y / N

Emergency Contact: _____ Phone: _____ Relation to Patient: _____

Parent (if minor) or Spouse Name: _____ Phone: _____

Parent (if minor) or Spouse SSN: _____ DOB: _____

Caretaker (if applicable): _____ Phone: _____

Referring Provider: _____ Phone: _____

Does the patient require POA (Power of Attorney) for medical decisions? Y / N

Who do you authorize to share your medical information with (med refills, condition, information in your records)?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Are you breastfeeding, pregnant, trying to get pregnant, or at risk of becoming pregnant? YES NO

EMPLOYER INFORMATION

Your Employer: _____ Phone: _____ Occupation: _____

Parent (if minor) or Spouse's Employer: _____ Phone: _____ Occupation: _____

NO-SHOW/24 HOUR CANCELLATION FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, **Edgebrook Dermatology: Medical, Laser & Aesthetic Center** reserves the right to charge a *fee for no shows or appointments canceled without a 24-hour advanced notice*. We understand extreme circumstances may occur and exceptions may be made if such situations arise. In the case of a no show or canceled appointment without a 24-hour advance notice, a fee of $65.00 will be charged for a regular appointment and a fee of $95.00 will be charged for a procedure/surgical appointment. This fee is out of pocket and **must be paid prior to your next visit**. Multiple no shows for one patient in any consecutive 12-month period may result in discharge/termination of care from our practice. **By signing below, you acknowledge that you have read, understood, and agree to fully comply with all terms and conditions of this policy, and all questions regarding this policy were answered to your satisfaction.**

_____ _____ _____
Patient Name Signature (or Parent/Guardian if Minor) Date

AUTHORIZATION AGREEMENT

Patient and/or responsible party must read and sign both sections below. If not signed and/or completed, full payment is required at the time of service.

I hereby authorize Edgebrook Dermatology: Medical, Laser & Aesthetic Center and/or its designee to verify employment and insurance coverage information provided with each employer and/or insurance carrier indicated, and to release the insurance carrier descriptions and/or results of tests, records, and financial information. In consideration of services rendered, I hereby irrevocably assign and transfer all rights, title, and interest in the benefits payable by insurance companies under which I am insured. I hereby authorize all insurance companies under which I am insured to pay these benefits directly to Edgebrook Dermatology: Medical, Laser & Aesthetic Center and/or designee. I will also pay for all charges incurred or, alternatively, for all charges in excess of the sums actually paid pursuant to said policies. Insurers may have different usual & customary rates/fees for various services. This clinic does not recognize the insurer's usual and customary. I hereby certify the information provided is true and correct to the best of my knowledge.

_____ _____
Patient or Responsible Party Signature Date

I understand that I am personally and fully financially responsible for payment of all charges for professional services rendered by Edgebrook Dermatology: Medical, Laser & Aesthetic Center. If the charges are not paid within 30 days of statement date, vendor may consult legal consult for assistance in collection of this account. All costs for such action, including attorney fees, court costs, collection agency fees, etc. shall be added to the account balance and shall be payable by the undersigned. I understand that if my insurance plan requires a referral for services to be covered, it is my responsibility to ensure availability of the properly completed referral form (physician's referral & approval of insurance company) before the time of service. Otherwise, I understand that I am responsible for non-covered charges as charged by clinic.

_____ _____
Patient or Responsible Party Signature Date

Please check all current or past medical conditions which apply to the patient.

PAST MEDICAL HISTORY

- ☐ Amnioglycoside
- ☐ Amyptrophic lateral sclerosis
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone marrow transplantation
- ☐ BPH / enlarged prostate
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes / prediabetes
- ☐ Eaton-lambert syndrome
- ☐ Epilepsy
- ☐ End stage renal disease
- ☐ Heart burn/GERD
- ☐ Heart valve problems
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Hyperpigmentation
- ☐ Hyperthyroidism
- ☐ Hypopigmentation
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lupus erythematosis
- ☐ Lymphoma
- ☐ Multipe sclerosis
- ☐ Myasthenia gravis
- ☐ Myopathy
- ☐ Neurological disorder
- ☐ Pacemaker
- ☐ PCOS
- ☐ Prostate cancer
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Valve replacement
- ☐ **NONE**
- ☐ **OTHER**: _____

PAST SURGICAL HISTORY

- ☐ Appendix removed
- ☐ Bladder removed
- ☐ Mastectomy (right, left, bilateral)
- ☐ Lumpectomy (right, left, bilateral)
- ☐ Breast biopsy (right, left, bilateral)
- ☐ Breast reduction
- ☐ Breast implants
- ☐ Colectomy: colon cancer resection
- ☐ Colectomy: diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder removed
- ☐ Coronary artery bypass
- ☐ PTCA
- ☐ Mechanical valve replacement
- ☐ Biological valve replacement
- ☐ Heart transplant
- ☐ Joint replacement: knee (right, left, bilateral)
- ☐ Joint replacement: hip (right, left, bilateral)
- ☐ Joint replacement within the last 2 years
- ☐ Kidney biopsy
- ☐ Kidney removed
- ☐ Kidney stone removal
- ☐ Kidney transplant
- ☐ Ovaries removed: Endometriosis
- ☐ Ovaries removed: cyst
- ☐ Ovaries removed: ovarian cancer
- ☐ Prostate removed: prostate cancer
- ☐ Prostate biopsy
- ☐ TURP
- ☐ Skin biopsy
- ☐ Basal cell cancer surgery
- ☐ Sqamous cell cancer surgery
- ☐ Melanoma surgery
- ☐ Spleen removed
- ☐ Testicals removed (right, left, bilateral)
- ☐ Hysterectomy: uterine cancer
- ☐ **NONE**
- ☐ **OTHER**: _____

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Basal cell carcinoma
- ☐ Squamous cell carcinoma
- ☐ Melanoma
- ☐ Blistering sunburns
- ☐ Dry skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Poison Ivy
- ☐ Flaky or itchy scalp
- ☐ **NONE**
- ☐ **OTHER**: _____

SKIN CARE

Do you wear sunscreen?	YES NO
If so, what SPF?	SPF _____
Do you tan or have you used tanning beds?	YES NO
When was your last exposure?	_____
Is your skin hypersensitive to light?	YES NO

FAMILY HISTORY

- ☐ Melanoma skin cancer — If so, who: _____
- ☐ Basal cell carcinoma — If so, who: _____
- ☐ Squamous cell carcinoma — If so, who: _____
- ☐ **NONE**
- ☐ **OTHER**: _____

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MEDICATIONS

Please check all medication, herbal supplements and vitamins you are taking.

- ☐ Aspirin
- ☐ Coumadin
- ☐ Epileptogenic medications
- ☐ Garlic pills
- ☐ Retin-A
- ☐ Retinol
- ☐ Renova
- ☐ Vitamin E
- ☐ St. John's Wort
- ☐ Tretinoin
- ☐ Tazorac
- ☐ **NONE**
- ☐ **OTHER (LIST BELOW)**

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE

Are you allergic to any medications or foods? **YES** **NO**

Please list any medication or food allergies: _____

_____

SOCIAL HISTORY

CIGARETTE SMOKING

- ☐ Never
- ☐ Former smoker: When did you quit? _____
- ☐ Smokes less than daily
- ☐ Smokes daily

SEXUAL HISTORY

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner
- ☐ Sexual partner of same gender

SAFETY

- ☐ I feel safe at home
- ☐ I do not feel safe at home

ILLICIT DRUG USE

- ☐ None
- ☐ IV drug use
- ☐ Inhalation drugs

ALCOHOL USE

- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks per day

Have you ever felt you should cut down on drinking?	YES	NO
Have people ever annoyed you by criticizing your drinking?	YES	NO
Have you ever felt bad or guilty about your drinking?	YES	NO
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	YES	NO

REVIEW OF SYMPTOMS

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ Rash
- ☐ Immuno suppression
- ☐ Hay fever
- ☐ Chest pain
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression
- ☐ **NONE**
- ☐ **OTHER**: _____

ALERTS

- ☐ Defibrillator
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic
- ☐ Allery to adhesive
- ☐ Allergy to latex
- ☐ Artificial heart valvge
- ☐ Artificial joints
- ☐ Blood thinners
- ☐ MRSA
- ☐ History of cold sores
- ☐ Pacemaker
- ☐ Pregnancy or planning a pregnancy
- ☐ Pre-medication to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ West Africa travel or contact
- ☐ Hepatitis
- ☐ AIDS / HIV
- ☐ **NONE**
- ☐ **OTHER**: _____

I certify all information provided is accurate. I understand cosmetic services are not covered by insurance.

Name: _____ Signature: _____ Date: _____