

**NEW PATIENT MEDICAL DATA**



Date: \_\_\_\_\_

SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Mr. / Mrs. / Ms. Birth Sex: \_\_\_\_\_  
 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

Do you have an Advance Care Plan, Power of Attorney, or Surrogate Medical Decision Maker? YES NO

If yes, please fill out the following:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**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

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

PAST SURGICAL HISTORY

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

SKIN DISEASE HISTORY

- |  |   |
|--|---|
| <input type="checkbox"/> Acne                    | <input type="checkbox"/> Eczema               |
| <input type="checkbox"/> Actinic keratosis       | <input type="checkbox"/> Psoriasis            |
| <input type="checkbox"/> Basal cell carcinoma    | <input type="checkbox"/> Poison Ivy           |
| <input type="checkbox"/> Squamous cell carcinoma | <input type="checkbox"/> Flaky or itchy scalp |
| <input type="checkbox"/> Melanoma                | <input type="checkbox"/> <b>NONE</b>          |
| <input type="checkbox"/> Blistering sunburns     | <input type="checkbox"/> <b>OTHER:</b> _____  |
| <input type="checkbox"/> Dry skin                |   |

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

- |  |                   |
|--|-------------------|
| <input type="checkbox"/> Melanoma skin cancer    | If so, who: _____ |
| <input type="checkbox"/> Basal cell carcinoma    | If so, who: _____ |
| <input type="checkbox"/> Squamous cell carcinoma | If so, who: _____ |
| <input type="checkbox"/> <b>NONE</b>             |                   |
| <input type="checkbox"/> <b>OTHER:</b> _____     |                   |



**MEDICATIONS**

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

- |  |                                       |  |  |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Aspirin                   | <input type="checkbox"/> Garlic pills | <input type="checkbox"/> Renova          | <input type="checkbox"/> Tretinoin                 |
| <input type="checkbox"/> Coumadin                  | <input type="checkbox"/> Retin-A      | <input type="checkbox"/> Vitamin E       | <input type="checkbox"/> Tazorac                   |
| <input type="checkbox"/> Epileptogenic medications | <input type="checkbox"/> Retinol      | <input type="checkbox"/> St. John's Wort | <input type="checkbox"/> <b>NONE</b>               |
|  |                                       |  | <input type="checkbox"/> <b>OTHER (LIST BELOW)</b> |

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**

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

**ALERTS**

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

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

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_