6140 W Atlantic Avenue * Delray Beach, FL 33484
Tel: (561) 498-4407 * (888) 357-DERM * Fax: (561) 498-4480
www.feinsteindermatology.com

Cosmetic Patient Information

Today's Date: __________________**Reason for visit:** ____

Patient Name: (Last) ________________________________ (First) ______________________ (Middle) _________

Permanent Address (Local): Street____

City/State/Zip ____

Secondary (Out of State) Address*: Street*____

City/State/Zip ____

Home Phone: (___) ________________ **Work Phone:** (___) ______________ **Cell:** (___) __________________

Social Security #: ________________ **Date of Birth:** _______________ **Approximate Weight:** __________

E-mail: ____

Sex: M F **Marital Status:** (Circle) Single Married Widowed Divorced Separated

Race: ______________ **Ethnicity:** _______________________ **Language Spoken:** _________________

Emergency Contact: ___________________________________ **Phone Number:** (____)____________________

Relationship to patient: ________________________________

Parent/Guardian of patient: ____________________________**Phone Number:**(_____)______________________

Primary Physician: ______________________________ **Phone Number:**(____)___________________________

Patient Occupation: _______________________________ **Referred By:** __________________________________

What skin care products have you used or currently using?____

Would you like to discuss skin care products with Dr. Feinstein and/or one of his assistants? Yes No

---

What type of cosmetic procedure are you interested in? ____

What parts of the body are you looking to have treated? ____

Have you had any prior cosmetic procedures? Circle Yes No

Please list prior cosmetic procedures and date performed? ____

____

Were you satisfied with your cosmetic procedure(s)? If not, why? ______________________________________

____

What skin care products have you used, currently use, or interested in?_________________________________

____

FEINSTEIN
DERMATOLOGY
& COSMETIC SURGERY

6140 W Atlantic Avenue * Delray Beach, FL 33484
Tel: (561) 498-4407 * (888) 357-DERM * Fax: (561) 498-4480
www.feinsteindermatology.com

LIFETIME AUTHORIZATIONS

For the release of medical records: I authorize the release of any medical information required by my insurance carrier(s) needed for this or any related claim. I authorize any holder and the health care financing administration or its intermediaries or carriers any information needed for this insurance claim or any related medical claim.

For the payment of benefits to the physician/provider: I, understand that Feinstein Dermatology & Cosmetic Surgery has agreed to accept Medicare and/or Health Insurance for payment of my bills by my signature below. I acknowledge and understand that I am fully responsible at the time of services for any yearly deductible, co-pay and/or coinsurance balance due which is to be paid by me to Feinstein Dermatology & Cosmetic Surgery. I further understand that should payment be denied due to "PRE-EXISITING ILLNESS", NON-COVERED OR TERMINATION OF COVERAGE, I will be responsible for payment of such fees within 10 days of such notification. I understand that I will be billed for the remaining unpaid balance and I understand that I am financially responsible for any charges not covered.

Self Pay Financial Policy: I understand, as a self-pay patient, that I am responsible to pay the bill at the time the services are rendered. These charges will include but not limited to consultation, laboratory fees, surgery fees and any other fees associated with my appointment.

Appointment Cancellation: Please be courteous and call Feinstein Dermatology and Cosmetic Surgery promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment we require that you give at least ***24 hours*** notice. Less than 24 hours notice doesn't allow us to offer an appointment to another patient in need. There will be a ***$50.00*** charge if you fail to show up for your scheduled appointment or cancel with less than 24 hours notice. Unavoidable circumstances may warrant special consideration, but please note that the above charges will apply to most cancellations. Thank you for understanding the importance of keeping your appointment.

METHOD OF PAYMENT

Payment is required at the time services are rendered. Feinstein Dermatology & Cosmetic Surgery is a participating provider with Medicare, most "PPO" and some HMO insurance plans. Please check with our receptionist to see if we participate with your health insurance plan. All medical claims will be filed automatically by our office. Please present your insurance card(s) to our receptionist for photocopying and benefit eligibility verification.

The information requested on this form must be completed in its entirety and will remain confidential. Your selection of Feinstein Dermatology & Cosmetic Surgery for your skin care is greatly appreciated. If you have any questions or require assistance, please do not hesitate to ask one of our staff members.

SIGNATURE: ________________________ PRINTED NAME:____________________ DATE:___________

FEINSTEIN
DERMATOLOGY
& COSMETIC SURGERY

6140 W Atlantic Avenue * Delray Beach, FL 33484
Tel: (561) 498-4407 * (888) 357-DERM * Fax: (561) 498-4480
www.feinsteindermatology.com

OPTIONAL COSMETIC PROCEDURES INTEREST

PATIENT NAME: ______________________________________ **DATE:** ____________________

AREA(S) OF CONCERN

☐ Brown Spots
☐ Age Spots
☐ Sun Damage
☐ Wrinkles
☐ Fine Lines
☐ Deep Lines
☐ Acne
☐ Acne Scars
☐ Hyperpigmentation
☐ Rosacea
☐ Sagging Eyelids
☐ Loose Skin
☐ Earlobe Repair
☐ Unwanted Hair
☐ Leg Veins
☐ Facial Veins
☐ Other

INTERESTS

☐ **LASER PROCEDURES**
☐ Laser Hair Removal
☐ BBL
☐ Erbium
☐ Thermascan
☐ Skin Tyte
☐ Facial Rejuvenation
☐ Laser Peels

SPECIFIC BODY PARTS

☐ Face
☐ Neck
☐ Chest
☐ Arms
☐ Hands
☐ Abdomen
☐ Legs
☐ Other

☐ **DERMAL FILLERS**
☐ Botox
☐ Juvederm
☐ Restylane
☐ Perlane
☐ Sculptra

OTHER TREATMENTS

☐ Sclerotherapy
☐ Earlobe Repair
☐ Peels
☐ Chemical Peels
☐ Neck Lift
☐ Blepharoplasty
☐ Other

6140 W Atlantic Avenue * Delray Beach, FL 33484
Tel: (561) 498-4407 * (888) 357-DERM * Fax: (561) 498-4480
www.feinsteindermatology.com

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, ______________________________ (Print Name) have been given the opportunity to read a copy of Feinstein Dermatology & Cosmetic Surgery's Notice of Patient Privacy Practices.

____ __________________________________

Signature of Patient Date

1. May we leave appointment information on your answering machine at home?

YES NO

(Circle One)

Please be advised that we are unable to leave any lab results on an answering machine.

2. Do you give our office permission to discuss you medical information with family members or other individuals (including spouse)?

YES NO

(Circle One)

If yes, please provide their names & phone numbers below.

Name: _______________________________ Relationship: __________________________
Phone # (day): ________________________ Phone (evening): _______________________

Name: _______________________________ Relationship: __________________________
Phone # (day): ________________________ Phone (evening): _______________________

6140 W Atlantic Avenue * Delray Beach, FL 33484
Tel: (561) 498-4407 * (888) 357-DERM * Fax: (561) 498-4480
www.feinsteindermatology.com

MEDICAL HISTORY FORM

Patient Name: ______________________________ DOB: ______________________ Date: ______________________________

ALLERGIES: ____ ____

____ ____

MEDICAL HISTORY

Please list current or prior:

____

____

____

____

MEDICATIONS

Please list current medications:

____

____

____

____

____

List Attached: Yes No

Pharmacy: __________________________

Phone #: ___________________________

HOSPITALIZATIONS

Please list your previous hospitalizations

____

____

____

SURGICAL HISTORY

Please list previous surgeries

____

____

DERMATOLOGIC HISTORY

Please check if ***YOU*** have a history of:

Melanoma	Yes	No
Squamous Cell Carcinoma	Yes	No
Basal Cell Carcinoma	Yes	No
Skin Cancer, Uncertain Type	Yes	No
Dysplastic (Atypical) Moles	Yes	No
Actinic Keratoses (Pre-Cancer)	Yes	No
Eczema/Psoriasis	Yes	No
Acne/Rosacea	Yes	No

Other ____________________________________

Year/Location: ______________________________

Treatment: _________________________________

____

FAMILY HISTORY

Melanoma	Yes	No
Squamous Cell Carcinoma	Yes	No
Basal Cell Carcinoma	Yes	No
Skin Cancer, Uncertain Type	Yes	No

Other ____________________________________

SOCIAL HISTORY

Alcohol None Yes: Amount ________________________

Tobacco None Yes: Amount ________________________

Drug Use None Yes: Amount ____________________

Lifetime Sun Exposure: Mild Moderate Heavy

History of Blistering Sunburn: Yes No

When in the sun, so you: Burn Tan Burn than tan

Sunscreen use: Always Occasionally Rarely

Ever use a tanning bed: No Yes, how many times? ________

____

PATIENT SIGNATURE

6140 W Atlantic Avenue * Delray Beach, FL 33484
Tel: (561) 498-4407 * (888) 357-DERM * Fax: (561) 498-4480
www.feinsteindermatology.com

REVIEW OF SYSTEMS

Patient Name:____ DOB: _________________ DATE: ________________________________

Please indicate below if you currently have or have had the following:

Systemic

HIV or AIDS	Yes	No	N/A
History of Rheumatic Fever	Yes	No	N/A
Weight Loss	Yes	No	N/A
Weight Gain	Yes	No	N/A
Hepatitis (Type: A, B, C)	Yes	No	N/A
Diabetes	Yes	No	N/A
High Cholesterol	Yes	No	N/A
High Blood Pressure	Yes	No	N/A
Herpes	Yes	No	N/A
Stroke	Yes	No	N/A
Epilepsy or Seizures	Yes	No	N/A

Eyes

Glaucoma	Yes	No	N/A
Cataracts	Yes	No	N/A

Ear, Nose, Mouth

Any Complaints	Yes	No	N/A

Cardiovascular

Swelling of Legs	Yes	No	N/A
Heart Attack	Yes	No	N/A
Pacemaker or Defibrillator	Yes	No	N/A

Respiratory

Shortness of Breath	Yes	No	N/A
Asthma	Yes	No	N/A
Hayfever, Seasonal Allergies	Yes	No	N/A

Urinary

Incotinence	Yes	No	N/A
Pain or Discomfort	Yes	No	N/A

Musculoskeletal

Muscle or Joint Pain	Yes	No	N/A
Arthritis	Yes	No	N/A
Artificial Joints	Yes	No	N/A

Female Issues

Currently Pregnant	Yes	No	N/A
Breastfeeding	Yes	No	N/A
Breast Lumps or Lesions	Yes	No	N/A

Male Issues

Testicular Lesions	Yes	No	N/A

Neurological

Dizziness	Yes	No	N/A
Numbness	Yes	No	N/A
Weakness	Yes	No	N/A
Headaches	Yes	No	N/A

Psychiatric

Depression	Yes	No	N/A
Anxiety	Yes	No	N/A

Dermatology

Skin Allergies	Yes	No	N/A
Bruises Easily	Yes	No	N/A
Hair or Nail Changes	Yes	No	N/A
New or Changing Moles	Yes	No	N/A
Dry or Sensitive Skin	Yes	No	N/A
Rashes	Yes	No	N/A
Bleeds Easily &/or Excessively	Yes	No	N/A
Keloids(scars) after Surgery	Yes	No	N/A
Problems Healing	Yes	No	N/A
History of Skin Cancer	Yes	No	N/A

____

Patient Signature