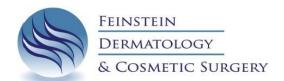


#### **Cosmetic Patient Information**

Today's Date:	Reason for visit:			
Patient Name: (Last)		(First)		(Middle)
Permanent Address (Local	): Street			
City/State/Zip				
Secondary (Out of State) Ad	ldress: Street			
City/State/Zip				
Home Phone: ()	Work Phone: (		Cell: ()	
Social Security #:	Date of Birth:	Appr	oximate Weigh	nt:
E-mail:				
Sex: M F	Marital Status: (Circle)	Single	Married	Widowed
		Divorce	d Separate	ed
Race: Et	hnicity:	Language Sp	oken:	
Emergency Contact:		Phone Numbe	r: ()	
Relationship to patient:				
Parent/Guardian of patien	t:	Phone Number:	()	
Primary Physician:	P	hone Number:(	)	
Patient Occupation:		Referred By:		
What skin care products hav	e you used or currently using?			
•	in care products with Dr. Feinste			
		• • • • • • • • • • • • • • • • • • • •		
What type of cosmetic proce	dure are you interested in?			
What parts of the body are y	ou looking to have treated?			
Have you had any prior cosr	netic procedures? Circle Yes	No		
Please list prior cosmetic pro	ocedures and date performed?			
Were you satisfied with your	cosmetic procedure(s)? If not, v	why?		
were you satisfied with you	cosmette procedure(s). It not,			
	eosmetic procedure(s). If not, v			



#### LIFETIME AUTHORIZATIONS

<u>For the release of medical records:</u> 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.

<u>Self Pay Financial Policy:</u> 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.

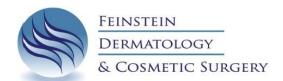
**Appointment Cancellation:** Please be courteous and call Feinstein Dermatology and Cosmetic Surgery promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment we require that you give at least **24 hours** notice. Less than 24 hours notice doesn't allow 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.

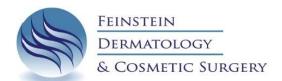
The information requested on this form must be completed in its entirety and will remain confidential. Your selection of Feinstein Dermatology & Cosmetic Surgery for your skin care is greatly appreciated. If you have any questions or require assistance, please do not hesitate to ask one of our staff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

SIGNATURE:	_ PRINTED NAME:	DATE:
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#### **OPTIONAL COSMETIC PROCEDURES INTEREST**

PATIENT NAME: DATE:						
AREA(S) OF CONCERN			INTERESTS			
	Brown Spots		LASER PROCEDURES		DERMAL FILLERS	
	Age Spots		Laser Hair Removal		Botox	
	Sun Damage		BBL		Juvederm	
	Wrinkles		Erbium		Restylane	
	Fine Lines		Thermascan		Perlane	
	Deep Lines		Skin Tyte		Sculptra	
	Acne		Facial Rejuvenation			
	Acne Scars		Laser Peels			
	Hyperpigmentation	SPECIFIC BODY PARTS		<u>OTH</u>	ER TREATMENTS	
	Rosacea		Face		Sclerotherapy	
	Sagging Eyelids		Neck		Earlobe Repair	
	Loose Skin		Chest		Peels	
	Earlobe Repair		Arms		Chemical Peels	
	Unwanted Hair		Hands		Neck Lift	
	Leg Veins		Abdomen		Blepharoplasty	
	Facial Veins		Legs		Other	
	Other		Other			



# **Receipt of Notice of Privacy Practices Written Acknowledgement Form**

l, _	, (Print Name	e) have been given the opportunity to read a copy of
Fe	Feinstein Dermatology & Cosmetic Surgery's Noti	ce of Patient Privacy Practices.
Sig	Signature of Patient	Date
1.	L. May we leave appointment information on yo	our 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.	2. Do you give our office permission to discuss y	ou medical information with family members or other
	individuals (including spouse)?	
	YES	NO
	(Circle One)	
	If yes, please provide their names	& phone numbers below.
Na	Name:	Relationship:
<del>.</del>		Phone (evening):
Na	Name:	Relationship:
Ph	Phone # (day):	Phone (evening):



# **MEDICAL HISTORY FORM**

Patient Name:	DOB:	Date:		
ALLERGIES:				
MEDICAL HISTORY		DERMATOLOGIC HISTORY		
Please list current or prior:		Please check if <b>YOU</b> have a history of:		
ricuse list current of prior.		Melanoma	Yes	No
		Squamous Cell Carcinoma	Yes	No
		Basal Cell Carcinoma	Yes	No
		Skin Cancer, Uncertain Type	Yes	No
		Dysplastic (Atypical) Moles	Yes	No
MEDICATIONS		Actinic Keratoses (Pre-Cancer)	Yes	No
Please list current medications:		Eczema/Psoriasis	Yes	No
		Acne/Rosacea	Yes	No
		Other		
		Year/Location:		
		Treatment:		
List Attached: Yes No		FAMILY HISTORY		
Pharmacy:		Melanoma Yes N		No
Phone #:		Squamous Cell Carcinoma	Yes	No
		Basal Cell Carcinoma	Yes	No
HOSPITALIZATIONS		Skin Cancer, Uncertain Type	Yes	No
Please list your previous hospitalizations		Other		
		SOCIAL HISTORY		
		Alcohol None Yes: Amount		
		Tobacco None Yes: Amount		
SURGICAL HISTORY		Drug Use None Yes: Amount _		
Please list previous surgeries				
		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 Occa	•	•
		Ever use a tanning bed: No Yes, how m	nany times	s?

**PATIENT SIGNATURE** 



#### **REVIEW OF SYSTEMS**

Patient Name:			DOB: _	DATE:			
Please indicate below if you currently have or have had the following:							
Systemic				Musculoskeletal			
HIV or AIDS	Yes	No	N/A	Muscle or Joint Pain	Yes	No	N/A
History of Rheumatic Fever	Yes	No	N/A	Arthritis	Yes	No	N/A
Weight Loss	Yes	No	N/A	Artificial Joints	Yes	No	N/A
Weight Gain	Yes	No	N/A				
Hepatitis (Type: A, B, C)	Yes	No	N/A	Female Issues			
Diabetes	Yes	No	N/A	Currently Pregnant	Yes	No	N/A
High Cholesterol	Yes	No	N/A	Breastfeeding	Yes	No	N/A
High Blood Pressure	Yes	No	N/A	Breast Lumps or Lesions	Yes	No	N/A
Herpes	Yes	No	N/A				
Stroke	Yes	No	N/A	Male Issues			
Epilepsy or Seizures	Yes	No	N/A	Testicular Lesions	Yes	No	N/A
Eyes				Neurological			
Glaucoma	Yes	No	N/A	Dizziness	Yes	No	N/A
Cataracts	Yes	No	N/A	Numbness	Yes	No	N/A
				Weakness	Yes	No	N/A
Ear, Nose, Mouth				Headaches	Yes	No	N/A
Any Complaints	Yes	No	N/A				
				Psychiatric			
Cardiovascular				Depression	Yes	No	N/A
Swelling of Legs	Yes	No	N/A	Anxiety	Yes	No	N/A
Heart Attack	Yes	No	N/A				
Pacemaker or Defibrillator	Yes	No	N/A	Dermatology			
				Skin Allergies	Yes	No	N/A
Respiratory				Bruises Easily	Yes	No	N/A
Shortness of Breath	Yes	No	N/A	Hair or Nail Changes	Yes	No	N/A
Asthma	Yes	No	N/A	New or Changing Moles	Yes	No	N/A
Hayfever, Seasonal Allergies	Yes	No	N/A	Dry or Sensitive Skin	Yes	No	N/A
				Rashes	Yes	No	N/A
Urinary				Bleeds Easily &/or Excessively	Yes	No	N/A
Incotinence	Yes	No	N/A	Keloids(scars) after Surgery	Yes	No	N/A
Pain or Discomfort	Yes	No	N/A	Problems Healing	Yes	No	N/A
				History of Skin Cancer	Yes	No	N/A