trū skin DERMATOLOGY

TODAYS DATE:_____

PATIENT'S PERSONAL INFORMATION

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

DATE OF BIRTH_____ SOCIAL SEC # _____ DRIVERS LICENSE #_____

ADDRESS _____ APT #_____ CITY _____ STATE____ ZIP: _____

PHONE: HM #_____ WK # _____ CELL #_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ PARTNERED SEX: ☐ MALE ☐ FEMALE ☐ TRANSGENDER

EMAIL_____ HOBBIES: _____ NUMBER OF CHILDREN: _____

EMPLOYER NAME: _____ADDRESS:_____OCCUPATION: _____

EMERGENCY CONTACT

_____ RELATIONSHIP _____ PHONE _____

PRIMARY CARE PHYSICIAN

DR. NAME: _____ DID THIS DOCTOR REFER YOU TO US? ☐ YES ☐ NO

IF YOU WERE NOT REFERRED BY YOUR DOCTOR, HOW DID YOU HEAR ABOUT US?

☐ INSURANCE COMPANY ☐ INTERNET ☐ PHONE BOOK ☐ FRIEND ☐ ADVERTISEMENT ☐ RADIO OTHER_____

PREFERRED PHARMACY

_____ADDRESS: _____CITY_____

PERSON RESPONSIBLE FOR BILL

(Complete only if different from patient) ☐ **SAME AS ABOVE**

NAME: _____ RELATIONSHIP_____

ADDRESS _____ APT #____ CITY _____ STATE____ ZIP: _____

DATE OF BIRTH: _____ PHONE: HOME _____CELL _____

PRIMARY MEDICAL INSURANCE

INSURANCE COMPANY: _____ EMPLOYER: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____ SSN _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY MEDICAL INSURANCE

INSURANCE COMPANY: _____ EMPLOYER: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____ SSN _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PATIENT NAME: _____ **DATE:** _____

MEDICAL HISTORY

ALLERGIES: PLEASE CHECK ANY **DRUG ALLERGIES** YOU HAVE. ☐ **NO KNOWN DRUG ALLERGIES**

☐ PENICILLIN ☐ KEFLEX ☐ SULFA ☐ BACTRIM-DS ☐ AMOXICILLIN ☐ CODIENE ☐ CIPRO/LEVAQUIN ☐ IODINE
☐ ADHESIVES ☐ LATEX ☐ EPINEPHRINE ☐ OTHER:_____

CURRENT MEDICATIONS AND SUPPLEMENTS: PLEASE CHECK ANY OF THE FOLLOWING THAT YOU TAKE EVERY DAY

☐ ASPIRIN ☐ PLAVIX ☐ COUMADIN ☐ WARFARIN ☐ PRADAXA ☐ EFFIENT ☐ AGGRENOX
☐ GARLIC ☐ FISH OIL ☐ GINKO BILOBA ☐ GINSENG ☐ VITAMIN E

PLEASE LIST ANY AND ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS, AS WELL AS VITAMINS/SUPPLEMENTS.

_____
_____
_____

ABOUT YOUR VISIT TODAY

WHAT CONCERNS WOULD YOU LIKE TO ADDRESS TODAY?

HOW CONCERNED ARE YOU ABOUT EXPERIENCING PAIN TODAY? (CHECK ONE) ☐ NOT AT ALL ☐ SOMEWHAT ☐ VERY CONCERNED

HOW CONCERNED ARE YOU ABOUT NEEDLES TODAY? (CHECK ONE) ☐ NOT AT ALL ☐ SOMEWHAT ☐ VERY CONCERNED

HAVE YOU EVER HAD PROBLEMS WITH PAIN OR NEEDLES AT DOCTOR'S OFFICES BEFORE? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO	If yes, please explain
ALLERGIES	☐	☐	_____
ARTHRITIS	☐	☐	_____
ASTHMA	☐	☐	_____
BLEEDING PROBLEMS	☐	☐	_____
BLOOD TRANSFUSION	☐	☐	_____
CONGESTIVE HEART FAILURE	☐	☐	_____
DIABETES	☐	☐	_____
HEART DISEASE	☐	☐	_____
HEPATITIS	☐	☐	_____
HIGH BLOOD PRESSURE	☐	☐	_____
HIGH CHOLESTEROL	☐	☐	_____
HIV	☐	☐	_____
KIDNEY DISEASE	☐	☐	_____
LIVER DISEASE	☐	☐	_____
LUNG DISEASE	☐	☐	_____
PSORIASIS	☐	☐	_____
SKIN DISEASE	☐	☐	_____
THYROID PROBLEMS	☐	☐	_____
OTHER	☐	☐	_____

FAMILY HISTORY: ARE THERE ANY SERIOUS HEALTH CONDITIONS ANY OF YOUR FAMILY MEMBERS HAVE HAD? IF YES, PLEASE EXPLAIN:

_____
_____

FEMALES ONLY:

ARE YOU PREGNANT? ☐ YES ☐ NO ARE YOU BREASTFEEDING? ☐ YES ☐ NO
ARE YOU TRYING TO GET PREGNANT? ☐ YES ☐ NO USING CONTRACEPTION? ☐ YES ☐ NO
IF YES, WHAT TYPE? _____

PATIENT NAME: _____ DATE: _____

YOUR SKIN AND HEALTH HABITS: CHECK ANY THAT APPLY, HOWEVER MINIMAL OR LONG AGO

	YES	NO	PLEASE EXPLAIN IF NEEDED
CAUCASIAN……	☐	☐	
FAIR SKIN/COMPLEXION……	☐	☐	
BLUE OR GREEN EYES……	☐	☐	
RED OR BLOND HAIR……	☐	☐	
SUNBURNED AT LEAST ONCE……	☐	☐	_____
TOBACCO SMOKING……	☐	☐	IF YES, HOW MANY PACKS PER DAY? _____
TOBACCO CHEWING……	☐	☐	IF YES, HOW MANY DIPS PER DAY? _____
TANNING SALON USER……	☐	☐	IF YES, HOW MANY TIMES PER MONTH? _____
ENJOY TANNING OUTDOORS……	☐	☐	IF YES, HOW MANY TIMES PER MONTH? _____
SKIN REDDENS OR FRECKLES EASILY……	☐	☐	_____
MANY MOLES / IRREGULAR MOLES……	☐	☐	_____
LIVED IN A SUNNY CLIMATE……	☐	☐	_____
I USE SUNSCREEN DAILY……	☐	☐	_____
I HAVE HAD SKIN CANCER/MELANOMA ……	☐	☐	_____
PARENT HAD SKIN CANCER/MELANOMA….	☐	☐	_____
SIBLING HAD SKIN CANCER/MELANOMA….	☐	☐	_____
ALCOHOL DRINKER……	☐	☐	IF YES, HOW MANY DRINKS PER DAY?_____
RECREATIONAL DRUG USE? ……	☐	☐	_____

1 IN 5 AMERICANS WILL GET SKIN CANCER, BUT WITH EARLY DETECTION IT HAS A 95% CURE RATE.
ASK US ABOUT A FULL SKIN CHECK TODAY IF YOU HAVE TIME OR WE CAN SCHEDULE ONE LATER!

SURGICAL PRE-OPERATIVE INFORMATION **PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU**

☐ MITRAL VALVE PROLAPSE ☐ ATRIAL FIBRILLATION ☐ NEED ANTIBIOTICS BEFORE DENTAL PROCEDURES

SURGICAL HISTORY: PLEASE CHECK ANY THAT YOU HAVE HAD:

☐ APPENDIX	☐ **ARTIFICIAL HEART VALVE**	☐ BACK/SPINE	☐ BREAST LUMPECTOMY
☐ CATARACTS	☐ CERVIX/UTERUS	☐ DEFIBRILLATOR	☐ EAR TUBES
☐ GALLBLADDER	☐ HEART STENT	☐ HEART BYPASS	☐ HERNIA
☐ **HIP REPLACEMENT**	☐ HYSTERECTOMY	☐ **KNEE REPLACEMENT**	☐ MOHS/SKIN SURGERY
☐ NECK/SPINE	☐ ORGAN TRANSPLANT	☐ PACEMAKER	☐ SHOULDER/ROTATOR CUFF
☐ SINUS	☐ TUBAL LIGATION	☐ TONSILS / ADENOIDS	☐ OTHER_____

SURGICAL CANCER HISTORY: PLEASE CHECK ALL THAT APPLY & THEIR TREATMENT(S)

	YES	**NO**	If yes, please provide year diagnosed and circle all treatments
BASAL CELL CARCINOMA, SKIN……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
BREAST CANCER……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
COLON CANCER……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
ENDOMETRIAL/UTERUS CANCER……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
LEUKEMIA/LYMPHOMA……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
LUNG CANCER……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
MELANOMA SKIN CANCER……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
PROSTATE CANCER……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
SQUAMOUS CELL CARCINOMA, SKIN…	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
THYROID CANCER……	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE
OTHER TYPE: _____	☐	☐	YEAR: _____ ☐ SURGERY ☐ RADIATION ☐ CHEMO ☐ NONE

PATIENT NAME: _____ DATE: _____

PLEASE CHECK ANY COSMETIC PROCEDURES OR SURGERIES THAT YOU HAVE HAD:

☐ BOTOX ☐ FILLERS ☐ RADIESSE ☐ CHEMICAL PEELS ☐ MICRODERMABRASION ☐ PHOTOFACIAL /IPL ☐ SKIN BLEACHING
☐ LIP AUGMENTATION ☐ LEG VEINS ☐ BREAST IMPLANTS ☐ BREAST REDUCTION ☐ TUMMY TUCK ☐ FACELIFT ☐ LIPOSUCTION
☐ NOSE RESHAPING ☐ EYELID SURGERY ☐ BROWLIFT

COSMETIC CONCERNS (OPTIONAL)

ARE YOU INTERESTED IN GETTING MORE INFORMATION ON THE COSMETIC OPTIONS THAT ARE AVALIABLE FOR THE TREATMENT OF SUN DAMAGE AND AGING SKIN? ☐ YES ☐ NO IF YES, CHECK BELOW:

☐ BOTOX ☐ FILLERS ☐ RADIESSE ☐ CHEMICAL PEELS ☐ MICRODERMABRASION ☐ PHOTOFACIAL /IPL
☐ SKIN BLEACHING ☐ LIP FILLERS ☐ LEG VEINS ☐ LASER HAIR REMOVAL ☐ FRAXEL LASER RESURFACING

ACKNOWLEDGEMENT OF OFFICE POLICIES

INSURANCE FILING AUTHORIZATION

I CERTIFY THAT THE INFORMATION CONTAINED IN MY REGISTRATION AND HEALTH HISTORY FORMS IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO DANIEL J. LADD JR, D.O., P.A./TRU-SKIN DERMATOLOGY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDANT, WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE . I ALSO AUTHORIZE DANIEL J. LADD JR, D.O., P.A./TRU-SKIN DERMATOLOGY OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I AGREE THAT A PHOTOCOPY OR SCAN OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

NOTICE OF PRIVACY PRACTICES

I HAVE READ A COPY OF TRU-SKIN DERMATOLOGY'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO EVALUATE OR TREAT MY CONDITION. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS ON MY BEHALF. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES.

PAYMENT POLICIES

PAYMENT IS DUE AT TIME OF SERVICE. THIS AMOUNT INCLUDES ANY CO-PAY AS WELL AS THE AMOUNT OF OUTSTANDING INSURANCE DEDUCTIBLE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDANT, WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE.

CANCELLATION POLICY

IF THE PATIENT CANNOT ADHERE TO A SCHEDULED APPOINTMENT, IT IS THE PATIENT'S RESPONSIBILITY TO CALL THE OFFICE TO CANCEL AT LEAST 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT. TRU-SKIN DERMATOLOGY RESERVES THE RIGHT TO CHARGE THE PATIENT A **$50 FEE** IF THE PATIENT DOES NOT CANCEL THE APPOINTMENT AT LEAST 24 HOURS IN ADVANCE. ADDITIONALLY, TRU-SKIN DERMATOLOGY RESERVES THE RIGHT TO RESCHEDULE APPOINTMENTS TO WHICH THE PATIENT IS MORE THAN 15 MINUTES LATE.

EMAIL COMMUNICATION

IT IS THE POLICY OF TRU-SKIN DERMATOLOGY TO NOT SHARE YOUR CONTACT OR EMAIL INFO WITH ANY THIRD PARTIES. OUR NEWSLETTER IS AVALIABLE TO YOU, BUT ONLY WITH YOUR PERMISSION:

☐ YES, I WANT YOU TO EMAIL ME A NEWSLETTER WITH DISCOUNTS ON COSMETIC SERVICES / PRODUCTS. YOU MAY USE THIS EMAIL ADDRESS:

_____

☐ NO, I DO NOT WANT YOU TO EMAIL ME THE NEWSLETTER AT THIS TIME.

PATIENT INITIALS (OR PARENT/GUARDIAN): _____ (to be filled out in person) PATIENT SIGNATURE _____

TREATMENT TO MINORS: MANY TIMES PARENTS ARE UNABLE TO ACCOMPANY THEIR TEEN OR CHILD UNDER AGE 18 TO APPOINTMENTS. IN SUCH AN EVENT I HEREBY GRANT TRU-SKIN DERMATOLOGY PERMISSION TO TREAT MY CHILD WHEN THEY ARRIVE AT THE OFFICE UNACCOMPANIED.

INITIALS of Parent or Guardian _____ (to be filled out in person) GUARDIAN SIGNATURE _____ _____
Date

PATIENT NAME: _____ DATE: _____

FEDERAL DATA ON RACE AND ETHNICITY

YOUR ANSWERS TO THE FOLLOWING QUESTIONS ALLOW U.S. FEDERAL AGENCIES TO COLLECT DATA ON YOUR RACE AND ETHNICITY. THE CATEGORIES IN THIS CLASSIFICATION ARE NOT TO BE USED AS DETERMINANTS OF ELIGIBILITY FOR PARTICIPATION IN ANY FEDERAL PROGRAM. THE STANDARDS HAVE BEEN DEVELOPED TO PROVIDE A COMMON LANGUAGE FOR UNIFORMITY AND COMPARABILITY IN THE COLLECTION AND USE OF DATA ON RACE AND ETHNICITY BY FEDERAL AGENCIES. (ADAPTED, *FEDERAL REGISTER*, OCTOBER 30, 1997)

ETHNICITY: ARE YOU HISPANIC OR LATINO?

☐ NO, I AM NOT **HISPANIC OR LATINO**.

☐ YES, I AM **HISPANIC OR LATINO**: A PERSON OF CUBAN, MEXICAN, CHICANO, PUERTO RICAN, SOUTH OR CENTRAL AMERICAN, OR OTHER SPANISH CULTURE OR ORIGIN, REGARDLESS OF RACE.

☐ I REFUSE TO ANSWER THIS QUESTION.

☐ I DON'T KNOW THE ANSWER TO THIS QUESTION.

WHAT IS YOUR RACE? YOU MAY SELECT ONE OR MORE RACES.

☐ **WHITE**: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF EUROPE, THE MIDDLE EAST, OR NORTH AFRICA.

☐ **BLACK OR AFRICAN AMERICAN**: A PERSON HAVING ORIGINS IN ANY OF THE BLACK RACIAL GROUPS OF AFRICA.

☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINALPEOPLES OF NORTH AND SOUTH AMERICA (INCLUDING CENTRAL AMERICA), AND WHO MAINTAINS TRIBAL AFFILIATION OR COMMUNITY ATTACHMENT.

☐ **ASIAN**: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF THE FAR EAST,SOUTHEAST ASIA, OR THE INDIAN SUBCONTINENT INCLUDING, FOR EXAMPLE, CAMBODIA, CHINA, INDIA, JAPAN, KOREA, MALAYSIA, PAKISTAN, THE PHILIPPINE ISLANDS, THAILAND AND VIETNAM.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF HAWAII, GUAM, SAMOA, OR OTHER PACIFIC ISLANDS.

☐ I REFUSE TO ANSWER THIS QUESTION.

☐ I DON'T KNOW THE ANSWER TO THIS QUESTION.

MY PREFERRED LANGUAGE IS: _____

☐ I REFUSE TO ANSWER THIS QUESTION.

☐ I DON'T KNOW THE ANSWER TO THIS QUESTION.