Patient Name: _____ Patient Date of Birth: _____

Insurance Information

Medical Insurance	Subscriber/Relation	Subscriber DOB	Subscriber Social Sec #/ Policy ID

Would you like us to bill medical? (Medical sometimes covers non-elective cosmetic surgeries)

Medical Health History

All past medical and dental history is important for your optimal care. Please take time to be accurate and thorough.

Current Physician (Name, Number, Date of Last Visit): _____ _____ _____

Current Dermatologist (Name, Number, Date of Last Visit) if applicable: _____ _____ _____

Current Medications (Prescription, Non-Prescription, Supplements): _____

_____

Current Topical Medications (Renova, Retin-A, Tazorac, Azalex) & Date of last use: _____

Current Skincare product regimen: _____

Pharmacy (Name, Number, Street Name): _____ _____ _____

Drug/Food/Latex Allergies: _____

Previous Surgeries or Hospitalizations or Serious Illness (including elective cosmetic surgery): _____

_____

Please Check All that apply

___ Allergies or Hay Fever
___ Arthritis or Rheumatism
___ Asthma
___ Cancer (Type & Year)
___ Chemical Peels, Laser Tx's
___ Child Birth
___ Colonoscopy
___ Alcoholic Beverages
___ Diabetes I or II
___ Dizziness, ringing, pain in ears
___ Epilepsy, convulsions, or seizure
___ Fever blisters or mouth ulcers
___ Frequent headaches
___ Glaucoma
___ Heart Attack or Chest Pain
___ Heart trouble (murmur, mitral valve prolapse)
___ Hepatitis, Herpes I or II or liver disease
___ High Blood Pressure
___ Injectables (Botox or dermal fillers)
___ Keloid scarring history
___ Kidney or bladder disease
___ Lung disease (TB, emphysema, etc.)
___ Mouth breathing or excessive snoring
___ Prosthetic devices (heart, valve, hip, etc.)
___ Pregnant
___ Psychiatric therapy or emotional problems
___ Rheumatic Fever
___ Sexually Transmitted Disease
___ Shortness of breath or swollen ankles
___ Sinus problems
___ Stroke
___ Subject to prolonged bleeding/bruise easily
___ Sun Exposure/ Tanning Bed (when)
___ Tattoos or Permanent Makeup
___ Tenderness or stiffness in jaw/neck/back
___ Thyroid problems
___ Ulcers or stomach problems
___ Use tobacco products
___ Wear contact lenses

The above Information is accurate and complete to the best of my knowledge.

Patient or Parent/Guardian Signature: _____ Date:

Office Use:

Skin Type: _____ Clinician's Initials: _____