



Today's Date: _____

Patient Information

First Name _____ Last Name _____ M.I. _____
Address: _____ DOB: _____ Sex: M F
City: _____ State: _____ Zip: _____ Social Security Number: _____ / _____ / _____
Home Phone: (____) _____ Email: _____
Work Phone: (____) _____ Primary Care Physician: _____
Cell Phone: (____) _____ Doctor's Phone: (____) _____
Whom may we thank for referring you? Dr _____ Patient _____
 Insurance Provider Website / Internet Other: _____

Insurance Information

Insurance Company Name: _____ **ID#:** _____
Insurance Company Phone Number: _____ **Group Number:** _____
Does your primary insurance require a referral ? YES NO
Subscriber's First Name: _____ Last Name: _____
Subscriber's DOB: _____ Sex: M F
Relationship to Patient: Self Spouse Child Other

Secondary Insurance (if applicable)

Insurance Company Name: _____ ID#: _____
Insurance Company Phone Number: _____ Group Number: _____
Does your secondary insurance require a referral ? YES NO
Subscriber's First Name: _____ Last Name: _____
Subscriber's DOB: _____ Sex: M F
Relationship to Patient: Self Spouse Child Other
ID#: _____ Group Number: _____ Phone Number: _____

Emergency Contact & Disclosure Information

First Name: _____ Last Name: _____
Relationship to Patient: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Work Phone: (____) _____ Other Phone: (____) _____
 I hereby give the emergency contact listed above permission to receive information from this office in my absence or on my behalf.
 I do NOT wish to use the emergency contact listed above. Instead, I hereby authorize the following person permission to receive information from this office in my absence or on my behalf:
Name: _____ Relationship to Patient: _____
Phone: (____) _____ Other Phone: (____) _____

Patient / Guardian Signature

Date



Patient Name: _____

Date: _____

Date of Birth: _____

Patient History Form

Patient Allergies / Medications	
Medication Allergies:	Current Medications:

Patient denies any allergies to medications

Patient denies taking any medications

Patient Past Medical History (check all that apply)		
Medical History	Yes	Details
Abdominal bleeding		
Asthma		
Breast Cancer		
Cancer		
Chest Pain/ tightness		
Diabetes		
Eczema		
Heart Disease		
Heart Murmur		
Hepatitis		
High Blood Pressure		
Hives		
Kidney Stones		
Skin Cancer		
Skin Disease		
Stroke		
Thyroid Disorder		
Tuberculosis		
Ulcer		
X-ray Therapy		
Other (please list)		

Patient denies any past medical history

Patient Past Surgical History (check all that apply)		
Past Surgery	Yes	Details
Angioplasty		
Appendix removed		
Artificial valve/ joint		
Colon removed		
Coronary artery bypass graft		
Gallbladder removed		
Hernia repair		
Hysterectomy		
Lumpectomy (breast)		
Mastectomy		
Pacemaker		
Skin cancer excision/ MOHS		
Tonsillectomy		
Tubal ligation (Tubes tied)		
Other (please list)		

Patient denies any past surgical history

Patient Family History (check all that apply)		
Family History	Yes	Afflicted Family Member
Abnormal Bleeding		
Abnormal Clotting		
Anesthesia Problems		
Autoimmune Disorder		
Breast Cancer		
Brain Tumor		
Other Cancer		
Cleft Lip		
Cleft Palate		
Diabetes		
Drug Allergies		
Endocrine Disease		
Hearing Loss		
Heart Disease		
High Blood Pressure		
Hemophilia		
Kidney Disease		
Liver Disease		
Lung Cancer		
Malignant Hyperthermia		
Ovarian Cancer		
Prostate Cancer		
Skin Cancer		
Skin Disease		
Substance Abuse		
Von Willebrand		
Other (please list)		

Patient denies any family history

Patient Social History (check all that apply)

Alcohol use

Denies alcohol use	<input type="checkbox"/>
Admits alcohol use socially	<input type="checkbox"/>
Admits alcohol use daily	<input type="checkbox"/>

Illegal Drugs

Denies illegal drug use	<input type="checkbox"/>
Admits illegal drug use	<input type="checkbox"/>

High Risk Factors

Denies high risk factors	<input type="checkbox"/>
Admits high risk factors	<input type="checkbox"/>

Tobacco use

Current smoker	<input type="checkbox"/>
Former smoker	<input type="checkbox"/>
Never smoker	<input type="checkbox"/>

Sexually Transmitted Disease History

Denies STD history	<input type="checkbox"/>
Admits STD history	<input type="checkbox"/>

Race (please check one)

Caucasian	<input type="checkbox"/>
African American	<input type="checkbox"/>
Hispanic or Latino	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Indian	<input type="checkbox"/>
Other	<input type="checkbox"/>
Decline to provide	<input type="checkbox"/>

Ethnicity (please check one)

Not Hispanic or Latino	<input type="checkbox"/>
Puerto Rican	<input type="checkbox"/>
Mexican	<input type="checkbox"/>
South American	<input type="checkbox"/>
Other	<input type="checkbox"/>
Decline to provide	<input type="checkbox"/>

What is your Primary Language? _____

Patient / Guardian Signature

Date



Specialty Pharmacy

As a courtesy to our patients, we recommend pharmacies that specialize in dermatology prescriptions. These pharmacies are equipped to process prescription rebate cards, and handle prior authorizations to reduce out-of-pocket costs for our patients. Our goal in using these pharmacies is to help secure the prescription that we, your providers, feel is the best medication for you.

- Yes, I would like to use a specialty.
- I would like to use my own pharmacy (please fill out section below).

Pharmacy name: _____

Pharmacy address: _____

Pharmacy Phone Number: _____

***South Jersey Skin Care & Laser Center, P.C. no longer handles prior authorizations on site. This means if your medication requires a prior authorization then the prescription will be sent to a specialty pharmacy for processing.**

South Jersey Skin Care & Laser Center, P.C has NO financial affiliation with any pharmacy.

I have read and understand the above statement.

Patient or Guardian signature

Date

Print Name

Date



COSMETIC INFORMATION REQUEST FORM

Please let us know if you would like additional information regarding any of the following cosmetic services and procedures:

- | | |
|--|--|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Waxing |
| <input type="checkbox"/> Superficial chemical peels | <input type="checkbox"/> extractions |
| <input type="checkbox"/> Injectable fillers (Juvederm/Radiesse/Belotero) | <input type="checkbox"/> miraDry (permanent sweat reduction) |
| <input type="checkbox"/> Laser Genesis (rosacea/redness/texture) | <input type="checkbox"/> truSculpt (body contouring) |
| <input type="checkbox"/> Pearl (skin rejuvenation for sun damage and wrinkles) | <input type="checkbox"/> Dermaplaning |
| <input type="checkbox"/> Limelight Solar Genesis (sun spots and freckling) | <input type="checkbox"/> Advanced anti-aging skin care products |
| <input type="checkbox"/> Kybella (permanent chin fat treatment) | <input type="checkbox"/> Latisse (for longer, thicker eyelashes) |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> HydraFacial MD |
| <input type="checkbox"/> Spider vein & facial vein treatment | <input type="checkbox"/> Dermaplaning |
| <input type="checkbox"/> Microdermabrasion | |

How did you hear about us?

- Family / friend referral Physician referral Internet / Website Insurance Provider
 Other: _____

Please let us know how to best contact you:

Name: _____

Home Phone: _____

Cell Phone: _____

Mailing Address: _____

Email Address: _____



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