South Jersey SKIN CARE & Laser Center

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 Physican: _____

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*

South Jersey SKIN CARE & Laser Center

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	☐
Admits alcohol use socially	☐
Admits alcohol use daily	☐

Illegal Drugs	
Denies illegal drug use	☐
Admits illegal drug use	☐

High Risk Factors	
Denies high risk factors	☐
Admits high risk factors	☐

Tobacco use	
Current smoker	☐
Former smoker	☐
Never smoker	☐

Sexually Transmitted Disease History	
Denies STD history	☐
Admits STD history	☐

Race (please check one)	
Caucasian	☐
African American	☐
Hispanic or Latino	☐
Asian	☐
Indian	☐
Other	☐
Decline to provide	☐

Ethnicity (please check one)	
Not Hispanic or Latino	☐
Puerto Rican	☐
Mexican	☐
South American	☐
Other	☐
Decline to provide	☐

What is your Primary Language? _____

_____

Patient / Guardian Signature **Date**

South Jersey SKIN CARE & Laser Center

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 _____

8/2016

South Jersey SKIN CARE & Laser Center

COSMETIC PATIENT HISTORY FORM

Date: _____

Full Name *(please print clearly)*		Date of Birth
Street Address		
City	State	Zip Code
Cell Phone	Other Phone	
( )	( )	
Email		

Personal Health History

Are you taking or have recently used any of the following?

☐ Aspirin/Motrin/Advil/Coumadin/Heparin ☐ Accutane ☐ Retinoid
☐ Glycolic Acid/ Alpha Hydroxy Acid ☐ Antibiotics ☐ Hydroquinone

If yes, how recent? _____

Have you experienced or do you have a history of :

☐ Keloid formation/ scarring ☐ HIV/AIDS ☐ Endocrine/ hormone issues
☐ Permanent Makeup-tattoo ☐ Lupus ☐ Hepatitis (List Type) _____
☐ Melanoma/ Skin cancer ☐ Easy Bruising ☐ Herpes/Cold Sores/ Fever Blisters

List any allergies:	***List any medications you are currently taking:***

Have you ever had an allergic reaction to any skin product or cosmetic? ☐ Yes ☐ No
Are you on hormone replacement therapy or birth control pills? ☐ Yes ☐ No
Are you pregnant or planning to be? ☐ Yes ☐ No
Are you breast feeding? ☐ Yes ☐ No
Do you have a history of tobacco use? ☐ Yes ☐ No ☐ Quit

Have you previously had any of the following Cosmetic Procedures?

☐ Fillers_____ ☐ Botox ☐ Surgery
☐ Laser Hair Removal ☐ Chemical Peel ☐ Microdermabrasion
☐ Photo Rejuvenation (IPL) ☐ Vein Therapy ☐ Non-ablative Skin Rejuvenation (Laser genesis)

Skin Type (when exposed to the sun for 1 hour without sun screen)

☐ White, always burns, never tans (I)
☐ Beige, usually burns, tans with difficulty (II)
☐ Light brown, sometimes burns, slow tanning (III)
☐ Medium brown, rarely burns, fast tanning (IV)
☐ Dark brown, rarely burns, fast and easy tanning (V)
☐ Black, almost never burns, fast and dark tanning (VI)

Patient 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 all that apply)		

☐ **NONE**

Patient / Guardian Signature **Date**

South Jersey SKIN CARE & Laser Center

COSMETIC INFORMATION REQUEST FORM

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

_____	Botox	_____	Waxing
_____	Superficial chemical peels	_____	HydraFacial MD
_____	Injectable fillers (Juvederm/Radiesse/Belotero)	_____	miraDry (permanent sweat reduction)
_____	Laser Genesis (rosacea/redness/texture)	_____	truSculpt (body contouring)
_____	Pearl (skin rejuvenation for sun damage and wrinkles)	_____	Eyebrow and eyelash tinting
_____	Solar Genesis (sun spots and freckling)	_____	Isolaz (acne/ deep pore cleansing)
_____	Kybella (permanent chin fat treatment)	_____	Dermaplaning
_____	Laser Hair Removal	_____	Advanced anti-aging skin care products
_____	Spider vein & facial vein treatment	_____	Latisse (for longer, darker eyelashes)
_____	Microdermabrasion	_____	Extractions

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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