



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: (\_\_\_\_) \_\_\_\_\_

**In order to provide you with swift patient care, may we leave detailed information on your voice mail?**  YES  NO

- 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 PATIENT HISTORY FORM**

Date: \_\_\_\_\_

Full Name <i>(please print clearly)</i>		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?*

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Aspirin/Motrin/Advil/Coumadin/Heparin | <input type="checkbox"/> Accutane    | <input type="checkbox"/> Retinoid                                   |
| <input type="checkbox"/> Glycolic Acid/ Alpha Hydroxy Acid     | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Hydroquinone <input type="checkbox"/> None |

***If yes, how recent?*** \_\_\_\_\_

*Have you experienced or do you have a history of :*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Keloid formation/ scarring | <input type="checkbox"/> HIV/AIDS      | <input type="checkbox"/> Endocrine/ hormone issues                                 |
| <input type="checkbox"/> Permanent Makeup-tattoo    | <input type="checkbox"/> Lupus         | <input type="checkbox"/> Hepatitis (List Type) _____ <input type="checkbox"/> None |
| <input type="checkbox"/> Melanoma/ Skin cancer      | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Herpes/Cold Sores/ Fever Blisters                         |

<b>List any allergies:</b>	<b>List any medications you are currently taking:</b>

- |   |                              |   |
|---|------------------------------|---|
| Have you ever had an allergic reaction to any skin product or cosmetic? | <input type="checkbox"/> Yes | <input type="checkbox"/> No                               |
| Are you on hormone replacement therapy or birth control pills?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No                               |
| Are you pregnant or planning to be?                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No                               |
| Are you breast feeding?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                               |
| Do you have a history of tobacco use?                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Quit |

- Have you previously had any of the following Cosmetic Procedures?
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fillers _____            | <input type="checkbox"/> Botox         | <input type="checkbox"/> Surgery  |
| <input type="checkbox"/> Laser Hair Removal       | <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Microdermabrasion                              |
| <input type="checkbox"/> Photo Rejuvenation (IPL) | <input type="checkbox"/> Vein Therapy  | <input type="checkbox"/> Non-ablative Skin Rejuvenation (Laser genesis) |
- None

- Skin Type (when exposed to the sun for 1 hour without sun screen)
- |   |  |
|---|--|
| <input type="checkbox"/> White, always burns, never tans (I)              | <input type="checkbox"/> Medium brown, rarely burns, fast tanning (IV)         |
| <input type="checkbox"/> Beige, usually burns, tans with difficulty (II)  | <input type="checkbox"/> Dark brown, rarely burns, fast and easy tanning (V)   |
| <input type="checkbox"/> Light brown, sometimes burns, slow tanning (III) | <input type="checkbox"/> Black, almost never burns, fast and dark tanning (VI) |



**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"/> Microneedling/PRP                      |
| <input type="checkbox"/> Superficial chemical peels                               | <input type="checkbox"/> HydraFacial MD                         |
| <input type="checkbox"/> Injectable fillers (Juvederm Family)                     | <input type="checkbox"/> miraDry (permanent sweat reduction)    |
| <input type="checkbox"/> Laser Genesis (rosacea/redness/texture)                  | <input type="checkbox"/> CoolSculpting (fat reduction)          |
| <input type="checkbox"/> PRP for hair loss  | <input type="checkbox"/> Eyebrow and eyelash tinting/ Waxing    |
| <input type="checkbox"/> IPL (sun spots, freckling, skin rejuvenation & wrinkles) | <input type="checkbox"/> Isolaz (acne/ deep pore cleansing)     |
| <input type="checkbox"/> Thread Lift ( loose & sagging skin)                      | <input type="checkbox"/> Dermaplaning                           |
| <input type="checkbox"/> Laser Hair Removal                                       | <input type="checkbox"/> Advanced anti-aging skin care products |
| <input type="checkbox"/> Spider vein & facial vein treatment                      | <input type="checkbox"/> Latisse (for longer, darker eyelashes) |
| <input type="checkbox"/> Microdermabrasion  | <input type="checkbox"/> 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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