DERMALOGIC Laser Center

PATIENT INFORMATION

Please Print

Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____ Gender: Male Female Marital Status: M S W D

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Preferred method of contact: _____

Address: _____ City/State: _____ Zip: _____

Occupation: _____ Employer: _____

Spouse or Contact person: _____

Drivers License number (if a minor, please use guarantor) Issuing State: _____ Number: _____

Email: _____ May we email you monthly skin care special offers: Y N

Referred by: (please specify in the space provided)

Self _____ Relative _____
Newspaper _____ Patient _____
Magazine _____ Spa _____
Yellow Pages _____ Employee _____
Friend _____ Other _____

Reason for today's visit: _____

_____

_____

Concerns (circle all that apply): loose skin - fullness under chin - folds around mouth - lines and wrinkles - look of neck - look of chest - hands - lips - sun spots - broken blood vessels - Rosacea redness - leg veins - spider veins - frown lines - crow's feet - acne - acne scaring - stretch marks - birthmarks - scars - unwanted hair - skin care products

AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize Dermalogic Laser Center to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Dermalogic Laser Center determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Dermalogic Laser Center.

I understand that I am responsible for any balance due for professional services.
I understand and acknowledge that payments for procedures are non-refundable.
I understand that in the event of collection action, I am responsible for any legal fees incurred.

Signature: _____ Date: _____

DERMALOGIC Laser Center

Acknowledgment and Consent

I understand that Dermalogic Laser Center of Hammonton, NJ (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority_____

DERMALOGIC Laser Center

MEDICAL HISTORY

Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____

ALLERGIES

List all Allergies:	Describe your Reaction:

CURRENT MEDICATIONS

Drug Name (brand/generic)	Dosage:	Schedule (frequency)

PAST MEDICAL HISTORY

Have you ever had any of the following? Please circle all that apply

Anemia	Depression	Heart Disease	Shortness of Breath
Ankle Swelling	Diabetes	Heart Attack	Stroke
Bleeding Tendency	Dizziness	Hearing Problems	Thrombophlebitis
Cancer	Emphysema	High Blood Pressure	Ulcer
Chest Pain	Endocrine Problem	HIV (AIDs)	Vision Problems
Coughing Blood	such as thyroid	Pneumonia	

Illnesses	Date	Hospitalizations	Date	Injuries	Date	List all surgeries	Date

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HISTORY OF TOBACCO

Have you ever smoked? Yes No If yes, when? _____

Are you currently smoking? Yes No

Cigarettes_____ How many a day?_____ How many years? _____

Cigars _____ How many a day?_____ How many years? _____

Smokeless tobacco _____ How many a day?_____ How many years? _____

HISTORY OF ALCOHOL

Do you drink alcohol? Yes No Recovery Alcoholic? Yes No Probably an Alcoholic? Yes No

Drink Alcohol____ How many times a week?_____ OR times a month? _____

Cigars _____ How many a day?_____ How many years? _____

Preferred beverage? _____

COSMETIC HISTORY

Have you had (Restylane, Collagen, etc.) injections? _____ Last injection? _____

Have you had Botox injections? _____ Last injection? _____

Have you ever been pregnant? YES NO How many times?_____ Live births?_____

Are you currently pregnant? YES NO Are you planning more children? YES NO

Have you used Accutane? _____ For how long? _____

Have you recently had facial surgery? _____ Type and date: _____

Have you ever had laser resurfacing? _____ Type and date: _____

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain _____

Have you had significant emotional problems? YES NO If yes, explain _____

Have you had psychiatric care? YES NO If yes, explain _____

Have you seen other plastic surgeons about this same problem? YES NO If yes, explain _____

Do you have high blood pressure? YES NO If yes, explain _____

Do you bleed easily from cuts or surgery? YES NO If yes, explain _____

Do you form large scars or keloids? YES NO If yes, explain _____

Do you have frequent infections or boils? YES NO If yes, explain _____

I hereby consent to be examined and treated by Amy Krachman, DO and that the above information is correct.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE