

PATIENT INFORMATION

Name: _____
First Name Initial Last Name Nickname

Date of Birth: ____ / ____ / ____ Sex: Male/Female Social Security # ____ - ____ - ____
MM DD YY

Marital Status: Single Married Divorced/Separated Widowed

Address: _____
Street Apt# City State Zip Code

Phone #'s: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____
Home Work Cell

Preferred Contact Line: Home / Work / Cell

E-mail Address: _____

How would you like to be reminded of your appointment? Text Message / Email / Phone message YES

Would you like to receive e-mails regarding special events and discounted cosmetic services? NO

MEDICAL INSURANCE(S)

Primary Insurance Co. _____ ID# _____ Relation: _____

Policy Holder name: _____ Date of Birth: ____ / ____ / ____ Group# _____

Address: _____

Secondary Insurance Co. _____ ID# _____ Relation: _____

Policy Holder name: _____ Date of Birth: ____ / ____ / ____ Group# _____

Address: _____

PRIMARY CARE PHYSICIAN

Full Name: _____ Phone#: (____) _____ - _____

Did this Doctor refer you? YES or NO

If "No," how did you find us? Internet/Insurance/Advertising/Event

Friendly Referral: _____ Other Doctor Referral: _____

PREFERRED PHARMACY

Name: _____ Cross streets: _____

Phone # (____) _____

EMERGENCY CONTACT

Name: _____ Phone# _____ Relationship: _____

PAST MEDICAL HISTORY

- Anxiety
- Arthritis
- Atrial Fibrillation
- Asthma
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Diabetes-Type:_____
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis

- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- OTHER:_____

NONE

PAST SURGERIES

Have you had surgeries on the following organs?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Mastectomy
 - Right Breast
 - Left Breast
 - Both Breasts
- Breast: Lumpectomy
 - Right Breast
 - Left Breast
 - Both Breasts
- Breast: Breast Biopsy
- Breast: Breast Reduction
- Breast: Breast Implants
- Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Gallbladder (Cholecystectomy)
- Heart: Coronary Artery Bypass Surgery
- Heart: PTCA
- Heart: Mechanical Valve Replacement
- Heart: Biological Valve Replacement
- Joint Replacement: Knee
 - Right Knee
 - Left Knee
 - Both knees

- Joint Replacement: Hip
 - Right Hip
 - Left Hip
 - Both Hips
- Kidney: Kidney Biopsy
- Kidney: Nephrectomy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Ovaries (Oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries (Oophorectomy): Ovarian Cancer
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): TURP
- Skin: Biopsy
- Skin: Basal Cell Carcinoma
- Skin: Squamous Cell Carcinoma
- Skin: Melanoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy):
 - Fibroids
 - Uterine Cancer
- Other:_____

NONE

SKIN DISEASE HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flaking or Itchy Scalp |
| <input type="checkbox"/> Actinic Keratoses (Precancerous lesions) | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> OTHER: _____
_____ | <input type="checkbox"/> NONE |

Do you wear sunscreen? YES or NO

If so, what SPF? _____

Do you use a tanning salon? YES or NO

FAMILY HISTORY

Do you have a family history of melanoma?
YES or NO

If yes, which relative?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Aunt |
| <input type="checkbox"/> Father | <input type="checkbox"/> Niece |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Nephew |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Grandmother |
| <input type="checkbox"/> Daughter | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Son | <input type="checkbox"/> Grandson |
| <input type="checkbox"/> Uncle | <input type="checkbox"/> Granddaughter |
| <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> NONE |

SOCIAL HISTORY

Please answer all questions thoroughly in order to give you the best of care

Smoking Status

- Current everyday smoker
_____ Packs a day
- Current some day smoker
- Former Smoker
_____ Year Quit
- Never Smoker

Sexual Activity

- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same Sex Partner

Drug Use

- None
- IV Drug Use

Alcohol Use

- None
- Less than 1 drink per day
- 1-2 Drinks per day
- 3 or more drinks

Home Environment

- Feels Safe At Home
- Feels Unsafe At Home

Caffeine Use

- Several Times a Day
- Once a Day
- Never

Exercise

- Daily
- Few times a week
- Never

OCCUPATION AND WORKPLACE

Occupation: _____

Workplace: _____

Approximately, how many hours does your job expose you to the sun each week? _____

EMERGENCY CONTACT FOR PATHOLOGY RESULTS

Please list a contact for pathology results if you cannot be reached

Name: _____ Phone# (____) _____

Relationship: _____

Demographics

Language at Home: _____

Race: _____

Ethnic Group: Hispanic/Latino
 Non Hispanic/Latino

Next of Kin: _____

Reason for Visit

INSURANCE POLICY

WE APPRECIATE THE OPPROTUNITY OF SERVING YOU.
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

INSURANCE POLICY:

As a courtesy to you, we will submit all itemized statements to your insurance carrier, if you have provided information. You are responsible for all deductibles, co-pay, co-insurance, etc, that are not covered by your insurance. Please understand we cannot, as a third party, become involved in prolonged negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any and all claims. I permit a copy of the authorization to be used in place of the original. Either my insurance company or I may revoke the authorization at any time in writing.

Signed: _____

Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the doctor/provider to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and in times when provider deems it necessary.

Signed: _____

Date: _____

Cancellation/ No Show Policy

Arizona Skin and Laser

Arizona Skin and Laser policy requires, minimum, 24-hour notice to cancel an appointment. If an accumulation of 3 cancellations without 24-hour notice and/or no shows occurs, we will discharge that patient from the practice.

Please sign to acknowledge your understanding and acceptance to comply with our office policy.

Patient Signature

Date

Print Patient Name

If you are a representative for the patient with their care please sign below

Representative Signature

Date

Print name and Title

For Office Use Only:

PATIENT COMMUNICATION SHEET

PATIENT NAME: _____

Date: _____

The following instructions pertain to the above named Patient:
(Please make appropriate selection)

_____ OK to call home and leave messages

_____ Do NOT leave messages

_____ Do NOT call home phone

***Call only this number: _____

_____ Do NOT speak to family members

_____ Permission to speak with ONLY family members listed below:

1. _____

Relation: _____

2. _____

Relation: _____

3. _____

Relation: _____

4. _____

Relation: _____

Signed: _____

Date: _____

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of Arizona Skin & Laser Inst. Ltd. "Notice of Privacy Practices." This notice describes how Arizona Skin & Laser Therapy Inst. Ltd. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare and the rights I may have regarding my protected health information.

Patient Signature

Date

Print Patient Name

***If you are a representative for the patient with their care please sign below

Representative Signature

Date

Print Name and Title