SKIN CREDIBLE

A Cosmoderm Specialist

WELCOME TO OUR OFFICE

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION
ALL INFORMATION IS STRICTLY CONFIDENTIAL

(Please Print Clearly)

PATIENT
NAME:____

LAST FIRST NICKNAME

DATE OF BIRTH: _____/____/____ AGE:______

ADDRESS____

STREET APARTMENT

____

CITY STATE ZIP

MARITAL STATUS___________________ SEX ( ) Male ( ) Female

Phone: Home ________________ Cell: _____________ Work:______________

E-Mail: ____

How did you hear about us? ____

CONTACT INFORMATION

EMERGENCY CONTACT #1

____

NAME NUMBER RELATIONSHIP TO PATIENT

EMERGENCY CONTACT#2

____

NAME NUMBER RELATIONSHIP TO PATIENT

PRIMARY CARE PHYSICIAN ___________________________ PHONE # ___________

REFERRING PHYSICIAN _______________________________ PHONE # ___________

PHARMACY: ____ PHONE # __________

PLEASE COMPLETE ALL PAGES **Initial: __________Date: _________**

INSURANCE INFORMATION

IF PATIENT is underage and/ or insured under a parent/guardian, or you are **not** the primary card holder, the following information is required.

Guarantor's Name____

Guarantor's Date of Birth: _______________ Social Security#__________________

Guarantor's Employer:___________________________Phone #________________

PRIMARY CARD HOLDER PATIENT INSURANCE INFORMATION

Primary Insurance: ____
Name of Insurance Carrier

I.D.#__________________________________Group #__________________

Subscriber Name on Card: ____

Employed: _____ If Employed: Name of Employer _______________________

Secondary Insurance:____
Name of Insurance Carrier

I.D.#___________________________________Group #___________________

IF you have any HMO type insurance, it is your responsibility to bring or order your referral electronically prior to your visit, and to check with the receptionist for number of visits left on a current referral

IF OUR OFFICE HAS A NEED TO CONTACT YOU HOW DO YOU WISH TO BE CONTACTED

PLEASE INDICATE YOUR PREFERENCE

( ) Home Phone______________________
- ( ) OK to leave message w/ detailed information
- ( ) Leave message with callback number only.

( ) Work Phone:______________________
- ( ) Leave message w/ callback number only.

( ) Cell Phone:_________________________
- ( ) OK to leave message w/ detailed information
- ( ) Leave message w/ callback number only.

( ) Written Communication
- ( ) OK to mail to home address
- ( ) OK to mail to work / office
- ( ) OK to fax to :___________________________
- ( ) Ok to sent to E-Mail address: ____

INQUIRY/ INFORMATION

SKIN CREDIBLE Offers many other procedures that you may also be interested in at a later Date. Please note which you might be interested in learning more about.

( ) Botox
( ) Chemical resurfacing
( ) Dermaplanning (Facial Hair removal)
( ) Fraxel
( ) Intense Pulse light for,
- ( ) Acne
- ( ) Hyperpigmentation
- ( ) Rosacea
- ( ) Telangectasia

( ) Laser Hair Removal
( ) Pixel Perfect
( ) Sclerotherapy
( ) Thermage and Body by Thermage
( ) Ultherapy

HEALTH HISTORY
Confidential

Your Health

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? ( ) No ( ) Yes
If yes, explain:____

2) Any recent surgery, including plastic surgery ( ) No ( ) Yes
If yes, explain: ____

3) Any skin cancer? ( ) No ( ) Yes
If yes, explain:____

4) Have you had any of these health conditions in the past or present?
(Please check all that apply and provide additional information below)

Cancer	( )	Headaches (chronic)	( )
Hormone imbalance	( )	Hepatitis	( )
High blood pressure	( )	Frequent cold sores	( )
Spinal injury	( )	Immune disorders	( )
Thyroid condition	( )	HIV/AIDS	( )
Hysterectomy	( )	Lupus	( )
Diabetes	( )	Metal bone pins or plates	( )
Heart Problem	( )	Phlebitis, blood clots, poor circulation	( )
Varicose veins	( )	Blood clotting abnormalities	( )
Arthritis	( )	Psychological treatment	( )
Asthma	( )	Skin diseases/ skin lesions	( )
Eczema	( )	Epilepsy	( )
Keloid scarring	( )	Seizure disorder	( )
Any active infection	( )	Fever Blisters	( )

If yes to any of the above please explain:____

Health History Continued

5) List any prescription medications you take regularly:

Meds:_________________________ Dose: ________________ Medical Condition: _____________________

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Meds: _________________________Dose: ________________ Medical Condition:_____________________

Meds: _________________________Dose: ________________ Medical Condition: _____________________

Meds: _________________________Dose:________________ Medical Condition: _____________________

Meds: _________________________Dose:________________ Medical Condition:______________________

Meds: _________________________Dose:________________ Medical Condition: ______________________

(If additional space needed, please add to the back of the page.)

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly.

____

____

6) Have you ever had an allergic reaction to any of the following? Please circle any that apply.

Cosmetics	Medicine	Food	Animals	Sunscreen	Iodine	Pollen
Fragrance	Shellfish	AHAS	Latex	Drugs	Other	

If YES to any of the above, please list name and reaction:____

____

7) Have you ever had an adverse reaction after using any skin product? (Please circle any that apply)

Rash Irritation Peeling Sun sensitivity Breakout

If YES, name product or ingredient of product:____

____

8) Do you use Tretinoin (Retin-A, Renova), Retinoid (Differin), Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products? ( )No ( ) Yes

9) Have you or do you take Accutane? ( )No ( ) Yes

10) Have you used an acne medication? ( ) No ( ) Yes, When? ________Which drug (s)________________

Health History Continued

PLEASE COMPLETE ALL PAGES **Initial: __________Date: _________**

11) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma ( ) No ( ) Yes, describe:

____

____

____

12) Do you smoke: ( ) No ( ) Yes

13) List your daily consumption of : Water: ____________ Caffeine: _____________ Alcohol: _____________

14) Do you follow a restricted diet? ( ) No ( ) Yes

15) What is your stress level? ( ) High ( ) Medium ( ) Low

16) Do you suffer from sinus problems? ( ) No ( ) Yes

17) Do you experience any problems sleeping? ( ) No ( ) Yes

18) Have you been exposed to the sun or used a tanning bed in the last 48 hours? ( ) No ( ) Yes

19) How frequently are you exposed to the sun or use a tanning bed?

______ Infrequently ______Frequently ______Regularly

20) HAS ANYONE IN YOUR FAMILY HAD:

	Father	Mother	Sibling	Aunt / Uncle
Cancer	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )
Heart Problems	( )	( )	( )	( )
Circulatory Problems	( )	( )	( )	( )
Stroke	( )	( )	( )	( )

Health Form completed

I received my copy of the HIPPA PRIVACY NOTICE FROM

SKIN CREDIBLE on:

DATE:________________________

SIGNATURE OF PATIENT:

____