

# AESTHETIC DERMATOLOGY, PC

PRINT NAME: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

Seen by any other Dermatologist? Y N By Whom? \_\_\_\_\_  
When/For what problems? \_\_\_\_\_

## 1. ALLERGIES: (Medications)

Allergic to any medicines:  
Penicillin Y N  
Lidocaine Y N  
Other: \_\_\_\_\_  
What happened: \_\_\_\_\_

## 2. PAST MEDICAL HISTORY:

Asthma/Bronchitis Y N  
Bleeding Problems Y N  
Drug or Alcohol Abuse Y N  
Glaucoma Y N  
Hayfever/Allergies Y N  
Heart Disease Y N  
Hepatitis Y N  
Hypertension Y N  
Keloid/Enlarged Scars Y N  
HIV/AIDS Y N  
Lung Disease Y N  
Pacemaker/Defibrillator Y N  
Poor/Non-Healing Wounds Y N  
X-Ray/Radiation Therapy Y N  
Location: \_\_\_\_\_  
Arthritis Y N  
Diabetes Y N

## 3. FAMILY HISTORY:

Basal Cell Carcinoma Y N  
Melanoma Y N  
Location: \_\_\_\_\_  
Other Skin Cancers: \_\_\_\_\_  
Anesthesia Problems Y N  
Allergies Y N  
Type \_\_\_\_\_  
Hay Fever Y N  
Asthma/Bronchitis Y N  
Eczema Y N  
Psoriasis Y N  
Other Skin Conditions: \_\_\_\_\_

## 4. SOCIAL HISTORY:

Are you pregnant? Y N  
Do you smoke? Y N  
Do you drink alcohol? Y N  
Do you use drugs? Y N  
Do you have a history of sunburns? Y N

## 5. MEDICATION(S):

CURRENT ORAL MEDICATIONS, HERBS, HEALTH FOODS (including birth control pills): \_\_\_\_\_

CURRENT TOPICAL & OVER-THE-COUNTER MEDICATIONS & CREAMS: \_\_\_\_\_

## 6. PERSONAL HISTORY:

Basal Cell Carcinoma Y N Blood Thinners Y N  
Squamous Cell Carcinoma Y N Use of Accutane Y N  
When \_\_\_\_\_  
Melanoma Y N When: \_\_\_\_\_  
Location/Year \_\_\_\_\_  
Have you had any cosmetic procedures? Y N  
Explain: \_\_\_\_\_  
Psoriasis Y N  
Eczema Y N  
Cancer Y N \_\_\_\_\_  
Aspirin Y N  
Other Skin Conditions: \_\_\_\_\_

## 7. LIST OTHER OPERATIONS, SURGERY OR MEDICAL PROBLEM:

## 8. GENERAL INFORMATION:

Height \_\_\_\_\_ Normal Blood Pressure \_\_\_\_\_ Weight \_\_\_\_\_ (lbs)

## 9. REFERRED BY: (circle one) INSURANCE DIRECTORY/DIRECT MAIL/NEWSPAPER/INTERNET/DOCTOR/FRIEND

INTERNET/ WEBSITE NAME: \_\_\_\_\_

DOCTOR or FRIEND'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: ( ) \_\_\_\_\_

PREFERRED PHARMACY NAME: \_\_\_\_\_

PREFERRED PHARMACY LOCATION: \_\_\_\_\_

NAME OF PRIMARY CARE DOCTOR: \_\_\_\_\_  
(IF NOT ABOVE)

**AESTHETIC DERMATOLOGY, PC**

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTION HEALTH INFORMATION-HIPAA CONSENT**

With my consent Aesthetic Dermatology, PC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Aesthetic Dermatology’s PC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices. Aesthetic Dermatology, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Aesthetic Dermatology, PC Privacy Officer.

With my consent, Aesthetic Dermatology, PC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice to carrying out TPO, such as appointment reminders, and insurance items and return calls requesting a call back.

With my consent, Aesthetic Dermatology, PC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Aesthetic Dermatology, PC may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Aesthetic Dermatology, PC restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent.

**WE OFFER A WIDE VARIETY OF SERVICES**

**ARE YOU INTERESTED IN ANY OF THE FOLLOWING  
PROCEDURES WE OFFER:**

Removal of Age Spots/Sun Spots	Y	N
<b>Botox®</b> : Forehead/Crow’s Feet/Between the Eyebrows Wrinkles	Y	N
Chemical Peel	Y	N
Excessive Fat/ CoolSculpting	Y	N
Facials/Aesthetician Services	Y	N
<b>Fillers</b> : Restylane®, Juvederm®, Fat	Y	N
Growth Removal	Y	N
Microdermabrasion	Y	N
Patch Testing for Skin Allergies	Y	N
Permanent Hair Removal (Reduction)	Y	N
Spider Veins	Y	N
Tattoo Removal	Y	N
Wrinkle /Rejuvenation <b>with downtime</b>	Y	N
Eyelash Extension: LATISSE®	Y	N
Removal of Broken Blood Vessels of the Face	Y	N
Removal of Hemangiomas/Port Wine Stains	Y	N

**We Offer Cosmetic Procedures For Men And Women**