



Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Preferred Contact Method: Home Work Cell E-mail Drivers License # _____ State _____

Age _____ Birthdate ____ / ____ / ____ SS# _____ Sex Female Male

Marital Status Single Married to: _____ Other: _____

Primary Care Physician: _____ Phone: _____

Referring Source: _____ Phone: _____

Patient's Employer _____ Occupation _____

Address _____
Street & Suite # City State Zip

Emergency Contact _____ Relationship to Patient _____
(Not in your household)

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____ Ins. Phone: _____

Policy # _____ Group # _____ Employer _____

Referral Required? No Yes Copay? No Yes, \$ _____ Relationship to Insured: _____

Insured: Name _____ DOB: _____ Social Security #: _____

Secondary Health Insurance Company _____ Ins. Phone: _____

Policy # _____ Group # _____ Employer _____

Referral Required? No Yes Copay? No Yes, \$ _____ Relationship to Insured: _____

Insured: Name _____ DOB: _____ Social Security #: _____

I understand that office visit charges are payable on the day service is rendered. I understand that I am responsible for all deductible, copay, and non-covered service amounts. I authorize Dr. Janet Lee to bill my insurance company. I authorize the release of any medical information necessary to process my claim. I also authorize payment of medical and surgical benefits to Dr. Janet Lee. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Janet Lee and myself. I understand that there is an office policy in effect that for all returned checks there will be an additional \$25.00 insufficient funds fee charge.

Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES – Patient Acknowledgement

I hereby acknowledge that I have read and reviewed the attached copy of the organization's Notice of Privacy Practices.

Patient Name: _____ **DOB:** _____ **Social Security #:** _____

Patient Signature: _____ **Relationship of Representative (if applicable)** _____

At any time you may request a copy of the organization's Notice of Privacy Practices for your records. Please notify the staff, if you would like them to supply you with an additional copy.

REASON FOR APPOINTMENT:

Patient: _____ Date of Birth: _____

Height: _____ Weight: _____ Date of last physical: _____

Drug Allergies: _____

Other Allergies: _____

Previous surgery, including cosmetic surgery (please list)

Operation	Year	Type of Anesthesia

Serious illnesses or hospitalizations, including childbirth (please list)

List all the medications you are now taking, please include dosage/frequency. Include over the counter drugs (ie. Aspirin, vitamins, herbal supplements, etc...)

What is your daily consumption of the following:

Tobacco: _____ Alcohol: _____

If you smoked in the past; how much, how long, and when did you quit?

Skin Care Routine:

Do you use Retin-A? Yes No How often? _____ what % _____

Do you use Alpha Hydroxy Acids (glycolic)? Yes No How often? _____

Could you possibly be pregnant? (Females Only) Yes No

Medical History: Please indicate if you have/had a history of the following:

- | | | | | | |
|--|-----------------------------|------------------------------|----------------|-----------------------------|------------------------------|
| Have you ever had a blood transfusion? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Lung Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Malignant hyperthermia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Radiation therapy to the face | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Tuberculosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| High blood pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Mental illness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Rheumatic Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blood/bleeding disorders | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Depression | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Gastrointestinal/stomach problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hepatitis/Liver disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | HIV | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Thyroid disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |

MD Reviewed

I acknowledge that I have disclosed all of my medical history known to me.

Patient's Signature: _____ **Date:** _____