



WELCOME TO OUR OFFICE!

PATIENT'S PERSONAL INFORMATION

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ INITIAL: \_\_\_\_\_
DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SEC # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX:  MALE  FEMALE  TRANSGENDER
ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP: \_\_\_\_\_
PHONE: HM # \_\_\_\_\_ WK # \_\_\_\_\_ CELL # \_\_\_\_\_
MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOWED  PARTNERED
EMAIL \_\_\_\_\_ HOBBIES: \_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_
EMPLOYER NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY CARE PHYSICIAN DR. NAME: \_\_\_\_\_ DID THIS DOCTOR REFER YOU TO US?  YES  NO
IF YOU WERE NOT REFERRED BY YOUR DOCTOR, HOW DID YOU HEAR ABOUT US?
 INSURANCE COMPANY  INTERNET  PHONE BOOK  FRIEND  ADVERTISEMENT  RADIO OTHER \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL (Complete only if different from patient)  SAME AS ABOVE

NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP: \_\_\_\_\_
DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ PHONE: HOME \_\_\_\_\_ CELL \_\_\_\_\_

PRIMARY MEDICAL INSURANCE

INSURANCE COMPANY: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_
POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_
POLICY HOLDER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_
RELATIONSHIP TO PATIENT:  SELF  SPOUSE  CHILD  OTHER

SECONDARY MEDICAL INSURANCE

INSURANCE COMPANY: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_
POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_
POLICY HOLDER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_
RELATIONSHIP TO PATIENT:  SELF  SPOUSE  CHILD  OTHER

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**MEDICAL HISTORY**

**ALLERGIES:** PLEASE CHECK ANY **DRUG ALLERGIES** YOU HAVE.  **NO KNOWN DRUG ALLERGIES**  
 PENICILLIN  KEFLEX  SULFA  BACTRIM-DS  AMOXICILLIN  CODIENE  CIPRO/LEVAQUIN  IODINE  
 ADHESIVES  LATEX  EPINEPHRINE  OTHER: \_\_\_\_\_

**CURRENT MEDICATIONS AND SUPPLEMENTS:** PLEASE CHECK ANY OF THE FOLLOWING THAT YOU TAKE EVERY DAY

ASPIRIN  PLAVIX  COUMADIN  WARFARIN  PRADAXA  EFFIENT  AGGRENOX  
 GARLIC  FISH OIL  GINKO BILOBA  GINSENG  VITAMIN E

**PLEASE LIST ANY AND ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS, AS WELL AS VITAMINS/SUPPLEMENTS.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\* PLEASE USE REVERSE SIDE TO LIST ADDITIONAL MEDICATIONS \*\*\*

**HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

	YES	NO	If yes, please explain
ALLERGIES.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
ARTHRITIS.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLEEDING PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLOOD TRANSFUSION.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
CONGESTIVE HEART FAILURE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEPATITIS.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH BLOOD PRESSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH CHOLESTEROL.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
KIDNEY DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
LIVER DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
LUNG DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSORIASIS.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
SKIN DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
THYROID PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**FAMILY HISTORY:** ARE THERE ANY SERIOUS HEALTH CONDITIONS ANY OF YOUR FAMILY MEMBERS HAVE HAD? IF YES, PLEASE EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_

**FEMALES ONLY:**

ARE YOU PREGNANT?  YES  NO ARE YOU BREASTFEEDING?  YES  NO  
ARE YOU TRYING TO GET PREGNANT?  YES  NO USING CONTRACEPTION?  YES  NO  
IF YES, WHAT TYPE? \_\_\_\_\_

**YOUR SKIN AND HEALTH HABITS: CHECK ANY THAT APPLY, HOWEVER MINIMAL OR LONG AGO**

	YES	NO	IF YES, PLEASE EXPLAIN
CAUCASIAN.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
FAIR SKIN/COMPLEXION.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
BLUE OR GREEN EYES.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
RED OR BLOND HAIR.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
SUNBURNED AT LEAST ONCE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
TOBACCO SMOKING.....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, HOW MANY PACKS PER DAY? _____
TOBACCO CHEWING.....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, HOW MANY DIPS PER DAY? _____
TANNING SALON USER.....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, HOW MANY TIMES PER MONTH? _____
TANNING DEVICE AT HOME.....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, HOW MANY TIMES PER MONTH? _____
ENJOY TANNING OUTDOORS.....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, HOW MANY TIMES PER MONTH? _____
SKIN REDDENS OR FRECKLES EASILY.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
MANY MOLES / IRREGULAR MOLES.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENJOY WATER OR SNOW SKIING.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
RADIATION FOR ACNE/THYROID .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
SUN EXPOSURE AT MY JOB.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
LIVED IN A SUNNY CLIMATE.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
I USE SUNSCREEN DAILY.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
I HAVE HAD SKIN CANCER/MELANOMA .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
PARENT HAD SKIN CANCER/MELANOMA....	<input type="checkbox"/>	<input type="checkbox"/>	_____
SIBLING HAD SKIN CANCER/MELANOMA....	<input type="checkbox"/>	<input type="checkbox"/>	_____
BREAST CANCER SURVIVOR.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
LEUKEMIA/LYMPHOMA SURVIVOR .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOL DRINKER.....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, HOW MANY DRINKS PER DAY? _____
RECREATIONAL DRUG USE? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**1 IN 5 AMERICANS WILL GET SKIN CANCER, BUT WITH EARLY DETECTION IT HAS A 95% CURE RATE.  
ASK US ABOUT A FULL SKIN CHECK TODAY IF YOU HAVE TIME OR WE CAN SCHEDULE ONE LATER!**

**SURGICAL PRE-OPERATIVE INFORMATION PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU**

- MITRAL VALVE PROLAPSE                       ATRIAL FIBRILLATION                       NEED ANTIBIOTICS BEFORE DENTAL PROCEDURES

**SURGICAL HISTORY: PLEASE CHECK ANY THAT YOU HAVE HAD:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> APPENDIX               | <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> BACK/SPINE              | <input type="checkbox"/> BREAST LUMPECTOMY     |
| <input type="checkbox"/> CATARACTS              | <input type="checkbox"/> CERVIX/UTERUS          | <input type="checkbox"/> DEFIBRILLATOR           | <input type="checkbox"/> EAR TUBES             |
| <input type="checkbox"/> GALLBLADDER            | <input type="checkbox"/> HEART STENT            | <input type="checkbox"/> HEART BYPASS            | <input type="checkbox"/> HERNIA                |
| <input type="checkbox"/> <b>HIP REPLACEMENT</b> | <input type="checkbox"/> HYSTERECTOMY           | <input type="checkbox"/> <b>KNEE REPLACEMENT</b> | <input type="checkbox"/> MOHS/SKIN SURGERY     |
| <input type="checkbox"/> NECK/SPINE             | <input type="checkbox"/> ORGAN TRANSPLANT       | <input type="checkbox"/> PACEMAKER               | <input type="checkbox"/> SHOULDER/ROTATOR CUFF |
| <input type="checkbox"/> SINUS                  | <input type="checkbox"/> TUBAL LIGATION         | <input type="checkbox"/> TONSILS / ADENOIDS      | <input type="checkbox"/> OTHER _____           |

**SURGICAL CANCER HISTORY: PLEASE CHECK ALL THAT APPLY & THEIR TREATMENT(S)**

	YES	NO	If yes, please provide year diagnosed and circle all treatments				
BASAL CELL CARCINOMA, SKIN.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
BLADDER CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
BREAST CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
COLON CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
ENDOMETRIAL/UTERUS CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
KIDNEY (RENAL CELL) CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
LEUKEMIA/LYMPHOMA.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
LUNG CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
MELANOMA SKIN CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
PROSTATE CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
SQUAMOUS CELL CARCINOMA, SKIN...	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
THYROID CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE
OTHER TYPE: _____	<input type="checkbox"/>	<input type="checkbox"/>	YEAR: _____	SURGERY	RADIATION	CHEMO	NONE

**PLEASE CHECK ANY COSMETIC PROCEDURES OR SURGERIES THAT YOU HAVE HAD:**

- BOTOX    FILLERS    Radiesse    CHEMICAL PEELS    MICRODERMABRASION    PHOTOFACIAL /IPL    SKIN BLEACHING
- LIP AUGMENTATION    LEG VEINS    BREAST IMPLANTS    BREAST REDUCTION    TUMMY TUCK    FACELIFT    LIPOSUCTION
- NOSE RESHAPING    EYELID SURGERY    BROWLIFT

**COSMETIC CONCERNS (OPTIONAL)**

ARE YOU INTERESTED IN GETTING MORE INFORMATION ON THE COSMETIC OPTIONS THAT ARE AVAILABLE FOR THE TREATMENT OF SUN DAMAGE AND AGING SKIN? \_\_\_YES \_\_\_NO IF YES, CHECK BELOW:

- BOTOX    FILLERS    Radiesse    CHEMICAL PEELS    MICRODERMABRASION    PHOTOFACIAL /IPL
- SKIN BLEACHING    LIP FILLERS    LEG VEINS    LASER HAIR REMOVAL    FRAXEL LASER RESURFACING

**ACKNOWLEDGEMENT OF OFFICE POLICIES**

**INSURANCE FILING AUTHORIZATION**

I CERTIFY THAT THE INFORMATION CONTAINED IN MY REGISTRATION AND HEALTH HISTORY FORMS IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO DANIEL J. LADD JR, D.O., P.A./AUSTIN CENTER FOR SKIN HEALTH AND REJUVENATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDANT, WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I ALSO AUTHORIZE DANIEL J. LADD JR, D.O., P.A./AUSTIN CENTER FOR SKIN HEALTH AND REJUVENATION OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I AGREE THAT A PHOTOCOPY OR SCAN OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

**NOTICE OF PRIVACY PRACTICES**

I HAVE READ A COPY OF AUSTIN SKIN DERMATOLOGY’S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO EVALUATE OR TREAT MY CONDITION. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS ON MY BEHALF. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES.

**PAYMENT POLICIES**

PAYMENT IS DUE AT TIME OF SERVICE. THIS AMOUNT INCLUDES ANY CO-PAY AS WELL AS THE AMOUNT OF OUTSTANDING INSURANCE DEDUCTIBLE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDANT, WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE.

**CANCELLATION POLICY**

IF THE PATIENT CANNOT ADHERE TO A SCHEDULED APPOINTMENT, IT IS THE PATIENT’S RESPONSIBILITY TO CALL THE OFFICE TO CANCEL AT LEAST 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT. AUSTIN SKIN DERMATOLOGY RESERVES THE RIGHT TO CHARGE THE PATIENT A \$50 FEE IF THE PATIENT DOES NOT CANCEL THE APPOINTMENT AT LEAST 24 HOURS IN ADVANCE. ADDITIONALLY, AUSTIN SKIN DERMATOLOGY RESERVES THE RIGHT TO RESCHEDULE APPOINTMENTS TO WHICH THE PATIENT IS MORE THAN 30 MINUTES LATE.

**EMAIL COMMUNICATION**

IT IS THE POLICY OF AUSTIN SKIN DERMATOLOGY TO NOT SHARE YOUR CONTACT OR EMAIL INFO WITH ANY THIRD PARTIES. OUR NEWSLETTER IS AVAILABLE TO YOU, BUT ONLY WITH YOUR PERMISSION:

- YES, I WANT YOU TO EMAIL ME A NEWSLETTER WITH DISCOUNTS ON COSMETIC SERVICES / PRODUCTS. YOU MAY USE THIS EMAIL ADDRESS:

\_\_\_\_\_

- NO, I DO NOT WANT YOU TO EMAIL ME THE NEWSLETTER AT THIS TIME.

PATIENT SIGNATURE (OR PARENT/GUARDIAN): \_\_\_\_\_

**TREATMENT TO MINORS:** MANY TIMES PARENTS ARE UNABLE TO ACCOMPANY THEIR TEEN OR CHILD UNDER AGE 18 TO APPOINTMENTS. IN SUCH AN EVENT I HEREBY GRANT AUSTIN SKIN DERMATOLOGY PERMISSION TO TREAT MY CHILD WHEN THEY ARRIVE AT THE OFFICE UNACCOMPANIED.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**FEDERAL DATA ON RACE AND ETHNICITY**

YOUR ANSWERS TO THE FOLLOWING QUESTIONS ALLOW U.S. FEDERAL AGENCIES TO COLLECT DATA ON YOUR RACE AND ETHNICITY. THE CATEGORIES IN THIS CLASSIFICATION ARE NOT TO BE USED AS DETERMINANTS OF ELIGIBILITY FOR PARTICIPATION IN ANY FEDERAL PROGRAM. THE STANDARDS HAVE BEEN DEVELOPED TO PROVIDE A COMMON LANGUAGE FOR UNIFORMITY AND COMPARABILITY IN THE COLLECTION AND USE OF DATA ON RACE AND ETHNICITY BY FEDERAL AGENCIES. (ADAPTED, *FEDERAL REGISTER*, OCTOBER 30, 1997)

**ETHNICITY: ARE YOU HISPANIC OR LATINO?**

- \_\_\_ NO, I AM NOT **HISPANIC OR LATINO**.
- \_\_\_ YES, I AM **HISPANIC OR LATINO**: A PERSON OF CUBAN, MEXICAN, CHICANO, PUERTO RICAN, SOUTH OR CENTRAL AMERICAN, OR OTHER SPANISH CULTURE OR ORIGIN, REGARDLESS OF RACE.
- \_\_\_ I REFUSE TO ANSWER THIS QUESTION.
- \_\_\_ I DON'T KNOW THE ANSWER TO THIS QUESTION.

**WHAT IS YOUR RACE? YOU MAY SELECT ONE OR MORE RACES.**

- \_\_\_ **WHITE**: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF EUROPE, THE MIDDLE EAST, OR NORTH AFRICA.
- \_\_\_ **BLACK OR AFRICAN AMERICAN**: A PERSON HAVING ORIGINS IN ANY OF THE BLACK RACIAL GROUPS OF AFRICA.
- \_\_\_ **AMERICAN INDIAN OR ALASKA NATIVE**: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF NORTH AND SOUTH AMERICA (INCLUDING CENTRAL AMERICA), AND WHO MAINTAINS TRIBAL AFFILIATION OR COMMUNITY ATTACHMENT.
- \_\_\_ **ASIAN**: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF THE FAR EAST, SOUTHEAST ASIA, OR THE INDIAN SUBCONTINENT INCLUDING, FOR EXAMPLE, CAMBODIA, CHINA, INDIA, JAPAN, KOREA, MALAYSIA, PAKISTAN, THE PHILIPPINE ISLANDS, THAILAND AND VIETNAM.
- \_\_\_ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF HAWAII, GUAM, SAMOA, OR OTHER PACIFIC ISLANDS.
- \_\_\_ I REFUSE TO ANSWER THIS QUESTION.
- \_\_\_ I DON'T KNOW THE ANSWER TO THIS QUESTION.

**MY PREFERRED LANGUAGE IS:** \_\_\_\_\_

- \_\_\_ I REFUSE TO ANSWER THIS QUESTION.
- \_\_\_ I DON'T KNOW THE ANSWER TO THIS QUESTION.