



Daniel J. Ladd, Jr., D.O. and Tom Yturri, PA

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La Grange
St. Mark's Medical Center
2 St. Mark's Place #110
La Grange, Texas 78945
Free: 888.451.0139

Patient Information

Date _____ Referring Physician/Primary Care Physician _____

Name _____ Date of birth _____
first/middle/last month/day/year

Age _____ Sex M F Marital status _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____

Home Phone (____) _____ Cell Phone (____) _____

Employed By _____ Work Phone (____) _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

Person Responsible For Payment

Name _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

If you are interested in COSMETIC PROCEDURES, Please check the following about your skin/body:

Uneven facial skin texture	<input type="checkbox"/> YES <input type="checkbox"/> NO	Spotty Facial Discoloration	<input type="checkbox"/> YES <input type="checkbox"/> NO
Facial Redness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Large Pores	<input type="checkbox"/> YES <input type="checkbox"/> NO
Brown Spots or freckles	<input type="checkbox"/> YES <input type="checkbox"/> NO	Facial Veins	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fine Lines and Wrinkles	<input type="checkbox"/> YES <input type="checkbox"/> NO	Forehead Wrinkles or Crow's feet	<input type="checkbox"/> YES <input type="checkbox"/> NO
Excessive armpit sweating	<input type="checkbox"/> YES <input type="checkbox"/> NO	Deeper lines around mouth	<input type="checkbox"/> YES <input type="checkbox"/> NO
Thin or wrinkled lips	<input type="checkbox"/> YES <input type="checkbox"/> NO	Deep Lines on Forehead or Frown Lines	<input type="checkbox"/> YES <input type="checkbox"/> NO
Face or Body Hair	<input type="checkbox"/> YES <input type="checkbox"/> NO	Unsightly Leg Veins	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cellulite	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stubborn Areas of Fat (thighs, buttocks)	<input type="checkbox"/> YES <input type="checkbox"/> NO



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Patient Name _____ Date: _____

Allergies: _____

Medications _____

Review of Systems

Do you have past or current problems with...

(If Yes, Explain)

- General Health YES NO _____
- Eyes YES NO _____
- Ears/Nose/Throat/Mouth YES NO _____
- Lungs YES NO _____
- Stomach/Bowels YES NO _____
- Kidneys YES NO _____
- Arthritis/Muscles/Joints YES NO _____
- Skin YES NO _____
- Headaches/Seizures YES NO _____
- Psychological Disorder YES NO _____
- Thyroid/Diabetes YES NO _____
- Blood/Bleeding/Disorder YES NO _____

Female Patients Only

Females: Are you pregnant? YES NO

Planning to become pregnant? YES NO

Past Family and Social History

Mother: Living/Deceased _____ Age _____ Father: Living/Deceased _____ Age _____

Number of Children _____ Age _____

Check the following medical conditions that have occurred in your family:

Disease	Mother	Father	Blood Relative	Disease	Mother	Father	Blood Relative
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Do you live alone? YES NO Married YES NO Do you smoke YES NO Yes-frequency _____

Do you drink alcohol? YES NO Yes-frequency _____ Do you use recreational drugs YES NO Yes-frequency _____

Occupation _____ Hobbies/Activities _____



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In order to serve you well and to avoid misunderstandings, we would like to inform you of our office policies:

Private Pay:

- Payment is expected when services are rendered, unless prior arrangements are made. We accept cash, check, MasterCard, Visa, Discover and American Express. A \$25 fee will be assessed for returned checks.
- 24-hour notification is required if you are unable to come for any type of office visit or procedure. As a courtesy, we will try to call and remind you of your appointment. However, you are still responsible for the appointment, even if we are unable to contact you.
- If we do not receive 24 hour notice prior to cancellation, you will be responsible for payment of the service as explained below. While we understand that unforeseen events can arise such as scheduling conflicts, illness, emergencies, etc., in order to fairly enforce this policy, there will be NO EXCEPTIONS made.

For missed appointments with Dr. Ladd - fee is \$50.

For missed appointments with the Aesthetician - fee is amount of Service Scheduled.

For missed procedures (Sclerotherapy, Sculptra, Aurora Laser, Botox, Restylane, and Mesotherapy)-fee is \$150.

Insurance Patients:

- Please present your insurance card(s).
- Your insurance benefits are a contract between yourself and the insurance company. If you feel that benefits were not paid correctly, please call your insurance company as we cannot call on your behalf.
- If Medicare is your primary and we are unable to receive payment from your secondary insurance, payment will become your responsibility.
- If we have filed your insurance and your claim has not been paid within 60 days, we may ask that you make a payment on the account. Any patient portions or private pay accounts not paid within 90 days are subject to being turned over to collections.
- Please note, WE DO NOT ACCEPT MEDICAID.

I have read and understand the above policies and agree to their terms. I have received a hard copy of Austin Skin's Notice of Privacy practices and I have requested a copy at my discretion.

Signature of Patient or Guardian

Date