

INTEGRATIVE DERMATOLOGY
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*****PATIENT INFORMATION*****

DATE: _____ CHART #: _____
 NAME: _____ SS#: _____ PHONE: _____
 CELL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status _____

Employer: _____ Occupation: _____

Business Phone: _____ E-Mail _____

Spouse's Name: _____ Phone: _____

Emergency Person: _____ Phone _____

Physician/Internist _____ Pharmacy Name & #: _____

List All Previous Surgeries/Hospitalizations: _____

Are you Allergic to any Medications? _____ If yes, list _____

List All Medications, Vitamins and Supplements You Are Taking (Please use back of page if necessary):

<u>Medications</u>	<u>Dosage</u>	<u>How Often</u>

PERSONAL DATA:

Height _____ Weight _____ #Children _____ Ages _____

Family or personal Hx Breast, prostate or Skin Cancer (Who) _____

Eye color _____ Hair color at age 20 _____

How easily do you tan? Not at all barely a little easily in no time

Check Any Of The Following Diseases Which You Have Or Have Had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Acne | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizure Disorder/Epilepsy |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Gout/Arthritis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Pancreas/gallbladder | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> H/O Skin Disease |
| <input type="checkbox"/> Squamous Cell Carcinoma | <input type="checkbox"/> X-ray therapy | <input type="checkbox"/> Blistering sunburns |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Illegal drug use | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Liver/Hepatitis/Jaundice | <input type="checkbox"/> Irregular/Fast Heartbeat | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Use of tanning beds |
| <input type="checkbox"/> Heart Attack/MI/Chest Pain | <input type="checkbox"/> TB/Cocci/Histoplasmosis | <input type="checkbox"/> Herpes / cold sore |

Reaction to local anesthetic

PT INITIALS _____

M.D. INITIALS _____

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FAMILY HISTORY: List immediate family members either deceased (with cause of death and age) or living with serious illness:

SOCIAL HISTORY: Please check and answer all of the following questions:

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you or anyone in your family had a problem with Anesthesia? If yes, please explain:
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems? If yes, please describe:
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? If yes, how much per day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a former smoker? If yes, when did you stop?
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcoholic beverages? If yes, how often?
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you on a special diet? If yes, describe:
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any disease, condition or problem not listed above that you think the doctor should know about? _____
If yes, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any reason to believe that you are pregnant? |

I have read (or have had read to me) the above medical information listing and I hereby certify that I have disclosed all of my medical history to the best of my knowledge that the information I have provided above is correct and to the best of my knowledge. I understand that I am financially responsible for all charges related to my procedure.

PT INITIALS: _____

MD INITIALS: _____

Our mission at Integrative Dermatology is to provide excellent care to our patients. We value your time, as we value ours. Many appointment times here are quite long, and if a patient fails to cancel, we sit idle when we could be helping other patients. Please help us provide excellent service by giving us at least 24 hours notice if you need to cancel an appointment. Please acknowledge this policy by signing below:

Signature

Date

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Please list the cosmetic procedures/surgeries you have already had:

COSMETIC PROCEDURES PERFORMED BY HAPPY/NOT/WHY?

I am here to see Dr. Laura E. Skellchock for: _____

I would like additional information on:

- | | |
|---|---|
| <input type="checkbox"/> Liposuction | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Tummy Tuck | <input type="checkbox"/> Breast Surgery |
| <input type="checkbox"/> Laser Surgery/PhotoFacial | <input type="checkbox"/> Lip augmentation |
| <input type="checkbox"/> Scar Revision | <input type="checkbox"/> Nasal Surgery |
| <input type="checkbox"/> Facial Implants/Sculptra/Restylane | <input type="checkbox"/> Anti-Aging/Hormone Treatment |
| <input type="checkbox"/> Facelift | <input type="checkbox"/> Age Spot Removal |
| <input type="checkbox"/> Browlift | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Midface Lift | <input type="checkbox"/> Facials |
| <input type="checkbox"/> Skin care products | <input type="checkbox"/> Eyelid Surgery |

Are you interested in our skin care program? YES NO

May our office contact you by phone? YES NO May we leave a message? YES NO

Are you interested in our E-Mail newsletter? YES NO

Your email is _____@_____

PLEASE TELL US HOW YOU HEARD ABOUT OUR PRACTICE:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Physician_____ | <input type="checkbox"/> Friend_____ |
| <input type="checkbox"/> Phone Book_____ | <input type="checkbox"/> Patient_____ |
| <input type="checkbox"/> Previous Patient_____ | <input type="checkbox"/> Other_____ |

PT. INITIALS: _____

M.D.INITIALS: _____

**INTEGRATIVE DERMATOLOGY
ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE**

I acknowledge that:

- I have received the attached Privacy Notice, OR
- I have been offered a copy of the Notice of the Privacy Practices but declined to accept a copy.

Patient Signature

Date

**WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

On (date) _____, the "NOTICE OF PRIVACY PRACTICES" was offered and/or given to (patient name) _____.

The Patient accepted a copy of the NOTICE OF PRIVACY PRACTICES but refused to sign an acknowledgement that it was given to the patient.

The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

Signature of employee offering the Notice

Date

Dr. Skellchock accepts insurance payment for medical procedures only. If you have both cosmetic and medical procedures done, the medical portion will be billed to your insurance company, while payment for cosmetic procedures are due at the time services are rendered. I have read the above and understand the same. I also understand that all insurance coverage fees (co-pays etc.) are non-negotiable.

Patient Signature

Date

Patient Signature

Date