

INTEGRATIVE DERMATOLOGY

Date: _____

★ IN ORDER TO EVALUATE YOU PROPERLY, ALL AREAS OF THIS FORM SHOULD BE FILLED OUT IN ITS ENTIRETY. ★
DUE TO THE SENSITIVE NATURE OF OUR EQUIPMENT, PLEASE TURN OFF YOUR CELL PHONE COMPLETELY WHILE IN THE OFFICE.

PLEASE PRINT:

Last Name: _____ First: _____ Middle _____

How do you like to be addressed? Mr. Mrs. Ms. Miss First Name: _____

Address: _____ Apt: _____ City: _____ State _____ Zip _____

SSN: _____ DOB: _____ Age _____ Marital Status: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Email Address: _____

If a Minor, Guardian Name: _____ Contact Number: _____

HIPAA PRIVACY POLICY & PHYSICIANS RELEASE

In compliance with the federal government we endorse the patient privacy act. This act, also known as HIPAA, ensures your medical record safety, but also inhibits us from obtaining essential medical information that may affect your procedure(s). This release gives our office the permission to acquire and distribute your testing and medical information. These records are shared only with essential medical personnel and the hospitals or surgical centers in which Dr. Skellchock is affiliated. Without this release we are unable to perform any procedure(s).

Patient Signature: _____

PHOTOGRAPHY CONSENT

I do hereby consent and authorize Laura E. Skellchock, M.D. to take photographs of me as it relates to my medical problem. I further authorize the use of the photographs for teaching, research and publications.

Patient Signature _____

OFFICE FINANCIAL POLICY

The patient is responsible to the above named physician for any and all charges incurred. Dr. Skellchock accepts insurance payment for medical procedures only. If you have both cosmetic and medical procedures, the medical portion will be billed to your insurance company, while payments for cosmetic procedures are due at the time services are rendered. There are absolutely no refunds for product(s) or service(s) rendered. A "NO SHOW" fee of \$50.00 will be charged if an appointment is not cancelled/re-scheduled within 24 hours of appointment time. I have read and will comply with the above stated "Office Financial Policy".

Patient Signature _____

REFERRED BY: (Please Specify)

Physician: _____ Radio: _____ Patient: _____

Magazine: _____ Website: _____ Other: _____

Seminar: _____ News: _____

I am here today because I would like to improve my appearance by: (Please be specific) _____

HOW DO YOU CURRENTLY TREAT YOUR SKIN?

- Retin-A How long? _____
- Sunscreen SPF: _____
- Moisturizer Name: _____

- Hydroquinone Name: _____
- Eye Cream Name: _____
- Other: _____

Are you happy with the appearance/texture of your skin? YES NO

HAVE YOU EVER HAD INJECTABLES? YES NO

If so, which ones? How long ago?

- Botox: _____
- Restylane: _____
- Radiesse: _____
- Collagen: _____

- Juvederm: _____
- Sculptra: _____
- Silicone: _____
- Other: _____

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
 Are you on a weight loss system or planning to lose weight? _____

MEDICAL HISTORY

Do you have or have you had any of the Following

- | | |
|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Scarlet/ Rheumatic fever |
| <input type="checkbox"/> Bone/Joint Disease | <input type="checkbox"/> Hay Fever/ Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis/ Rheumatism |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Bruise/ Bleed Easily |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Problems with Anesthesia |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Are you pregnant, nursing or planning to get pregnant? | |

ALLERGIES

List all allergies : Reaction:

- | | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

SOCIAL HISTORY

- Aspirin (how many a day) _____
- Alcohol (drinks per day) _____
- Cigarettes(per day) _____
- Vitamins(list on next page) _____
- Recreational Drugs? _____

Patient Initials _____

CURRENT MEDICATIONS:

- | | | |
|------------------|------------------------|---------------|
| Medication _____ | Dosage/Frequency _____ | Purpose _____ |
| Medication _____ | Dosage/Frequency _____ | Purpose _____ |
| Medication _____ | Dosage/Frequency _____ | Purpose _____ |
| Medication _____ | Dosage/Frequency _____ | Purpose _____ |
| Medication _____ | Dosage/Frequency _____ | Purpose _____ |

Please provide us your Pharmacy Phone Number: _____

PAST SURGERIES/ HOSPITAL ADMISSIONS

Type _____ Date _____ Doctor _____ Side Effects _____

Type _____ Date _____ Doctor _____ Side Effects _____

Type _____ Date _____ Doctor _____ Side Effects _____

FAMILY MEDICAL HISTORY:

FATHER: Age _____ Health Problem _____ Cause of Death _____

MOTHER: Age _____ Health Problem _____ Cause of Death _____

SIBLINGS: Age _____ Health Problem _____ Cause of Death _____

OTHER: Age _____ Health Problem _____ Cause of Death _____

I WOULD LIKE ADDITIONAL INFORMATION ON:

- | | |
|---|---|
| <input type="checkbox"/> Acne Treatment | <input type="checkbox"/> Laser Skin Rejuvenation |
| <input type="checkbox"/> Age or Sun Spot Removal | <input type="checkbox"/> Lip Augmentation |
| <input type="checkbox"/> Anti-Aging/Bio-Identical Hormone Replacement | <input type="checkbox"/> Liquid Facelift |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Neck Treatments |
| <input type="checkbox"/> Cellulite Reduction | <input type="checkbox"/> Photofacials |
| <input type="checkbox"/> Dysport | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Eyelash Growth | <input type="checkbox"/> Soft Tissue Augmentation |
| <input type="checkbox"/> Facials | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Laser Hair Removal | |

Patient Initials _____

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