Main Line Center for Laser Surgery
32 Parking Plaza, Suite 200
Ardmore, PA 19003

THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY

PATIENT INFORMATION FORM

NAME _____
(Last) (First) (Middle)

SS#_____BIRTHDATE_____SEX: M F MARITAL STATUS: S M D W

HOME ADDRESS _____
(Street) (Apt) (City) (State) (Zip)

HOME PHONE_____ E-MAIL _____

WORK PHONE_____ CELL PHONE_____

OCCUPATION_____

EMPLOYER NAME_____

RESPONSIBLE PARTY INFORMATION: *(IF OTHER THAN PATIENT)*

NAME_____
(Last) (First) (Middle)

RELATIONSHIP TO PATIENT_____

SS# OF INSURED_____BIRTHDATE OF INSURED_____

HOME ADDRESS_____
(Street) (City) (State) (Zip Code)

HOME PHONE_____

☐ I HAVE NO INSURANCE COVERAGE *(PLEASE CHECK IF APPROPRIATE)*

REFERRED BY ☐*PHYSICIAN* ☐*FRIEND* ☐*INTERNET* ☐*OTHER* _____PHONE #_____

ADDRESS _____

PRIMARY CARE PHYSICIAN _____ PHONE #_____

ADDRESS _____

EMERGENCY CONTACT _____RELATIONSHIP _____

PHONE_____

I do hereby agree to pay the full and entire amount of the **consultation fee in addition to all bills for services rendered**.

_____
(Sign Name) (Date)

As a member of a managed care group, I assume all responsibility for any services rendered that are not a part of my referral, whether or not covered or paid by my insurance, and **I will pay for those services at the time they are rendered**.

_____
(Sign Name) (Date)

WORKER'S COMPENSATION AND OTHER PERSONAL INJURY TESTIMONY IN COURT

In order to provide the best possible service, care and availability to all of our patients, **it is our policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action**.

_____
(Sign Name) **(Date)**

Specialized Care

I understand that the Main Line Center for Laser Surgery is a tertiary referral practice. The physicians at our center will evaluate the specific problem for which you have been referred or have sought treatment. General dermatologic care and evaluation is the responsibility of the referring or primary physician. If you require a referral to a general dermatologist, please notify our office.

_____
(Sign Name) **(Date)**

Reason for visit_____

How long have you had this problem?_____

Name of General Dermatologist_____

Do you see a Skin Care specialist or Esthetician?_____

Have you recently had any other treatments such as Botox or fillers?_____

Have you ever been on Accutane? YES NO **If yes please also inform the doctor verbally**

If you were on Accutane when_____

Do you have or have a history of **Cold Sores**? NO YES

Do you have or have a history of Scarring or Keloids? NO YES

Have you recently had a hormonal work-up for excessive hair growth? NO YES If yes when_____

Do you have regular menstrual cycles? NO YES

Do/have you ever had permanent makeup/tattoos? NO YES If yes please also inform the doctor verbally

If yes where? Eyebrows Eyeliner Lip liner Other_____

Have you ever had Gold Therapy? NO YES If yes please also inform the doctor verbally

Are you pregnant at this time? NO YES

Do you faint when having blood drawn? NO YES

SOCIAL HISTORY: *(CHECK ALL THAT APPLY)*

Do you smoke? ☐ **NO** ☐ **YES - Frequency**_____

Do you use recreational drugs? ☐ **NO** ☐ **YES - Frequency**_____

Do you drink alcohol? ☐ **NO** ☐ **YES - Frequency**_____

DRUG ALLERGIES: *(LIST TYPE OF REACTION)*

☐ **ANESTHETICS**_____ ☐ **ASPIRIN**_____

☐ **CODEINE**_____ ☐ **ERYTHROMYCIN**_____

☐ **PENICILLIN**_____ ☐ **SULFA**_____

☐ **TETRACYCLINE**_____ ☐ **OTHERS,** ***please list***_____

NON-DRUG ALLERGIES: ☐ **LATEX**

☐ **OTHER** ***(SPECIFY)***_____

PRE-MEDICATION REQUIRED PRIOR TO SURGERY ☐ **NO** ☐ **YES** - ***List drug, dosage & duration***_____

PRESENT/PAST MEDICAL HISTORY: *(LIST CONDITIONS AND DATE)*

_____

_____

ARE YOU CURRENTLY TAKING MEDICATION?

☐ **YES** ☐ **NO** **IF SO, PLEASE LIST:**_____

SURGICAL HISTORY: ***(LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)***

_____