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**_____ **MARITAL STATUS: S M D W**

GENDER ASSIGNED AT BIRTH_____ **GENDER IDENTITY**_____ **PRONOUN**_____

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 <u>ever</u> 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)***

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY OF PATIENT *(CHECK ALL THAT APPLY; USE C. IF CURRENT, USE P IF PAST)*

CONSTITUTIONAL SYMPTOMS:

____ Fever ____ Hair loss
____ Weight loss ____ Weight gain
____ Chills ____ Tremor
____ Nutritional Deficiencies
____ Other, specify_____

EYES:

____ Cataracts ____ Glaucoma
____ Eyestrain ____ Blurring
____ Inflammation
____ Wear glasses
____ Wear contacts
____ Other, specify_____
Date of last eye exam_____

EARS, NOSE, MOUTH, THROAT:

____ Hearing difficulty
____ Pain ____ Discharge
____ Tinnitus (ringing in ears)
____ Dizziness ____ Wear hearing aid
____ Sinusitis ____ Postnasal drip
____ Obstruction
____ Gum Disease
____ Chronic sores
____ Herpes simplex infections
____ Soreness ____ Redness
____ Hoarseness
____ Other, specify_____

CARDIOVASCULAR:

____ Stroke ____ Palpitation
____ Pacemaker ____ Rheumatic Fever
____ Faintness ____ Pain
____ High blood pressure
____ Heart surgery
____ Edema (swelling)
____ Heart valve replacement
____ Other, specify_____

INFECTIOUS:

____ HIV Positive ____ AIDS Virus
____ Hepatitis

RESPIRATORY:

____ Asthma ____ Chest pain
____ Emphysema ____ Tuberculosis
____ Lung disease
____ Breathing disorder
____ Bronchitis, chronic
____ Sputum, with blood
____ Cough, chronic
____ Upper respiratory infection, chronic
____ Other, specify_____

GASTROINTESTINAL:

____ Ulcer ____ Pain
____ Nausea ____ Constipation
____ Diarrhea ____ Vomiting
____ Appetite decrease
____ Colon/intestinal disorder
____ Other, specify_____

GENITOURINARY:

____ Discharge ____ Urgency
____ Sores ____ Incontinence
____ Hesitancy
____ Herpes simplex infections
____ Other, specify_____

MUSCULOSKELETAL:

____ Arthritis ____ Lupus
____ Joint pain ____ Lupus of the skin
____ Weakness ____ Joint swelling
____ Joint replacement
____ Cold sensitivity
____ Other, specify_____

INTEGUMENTARY:

____ Skin cancer(s)
____ Acne ____ Hives
____ Warts ____ Psoriasis
____ Eczema ____ Cystic Acne
____ Loss of Pigment
____ Contact dermatitis
____ Malignant Melanoma
____ Scarring/keloids
____ Herpes simplex (cold sores)
____ Herpes Zoster (shingles)
____ Other, specify_____

NEUROLOGICAL:

____ Headaches ____ Convulsions
____ Seizures ____ Migraine headaches
____ Epilepsy ____ Fainting spells
____ Memory loss
____ Other, specify_____

PSYCHIATRIC:

____ Stress ____ Depression
____ Nightmares ____ Insomnia
____ Anxiety ____ Suicidal Tendency
____ Treatment of psychological disorder
____ Other, specify_____

ENDOCRINE:

____ Thyroid disorder
____ Diabetes mellitus
____ Excessive hair, face/body
____ Other, specify_____

HEMATOLOGIC/LYMPHATIC:

____ Anemia ____ Bruise easily
____ Blood clots ____ Excessive bleeding
____ Other, specify_____

ALLERGIC/IMMUNOLOGIC:

____ Asthma ____ Frequent infections
____ Allergies ____ Thyroiditis
____ Vitiligo ____ Addison's Disease
____ Pernicious anemia
____ Hay Fever
Other, specify_____

MALES ONLY:

____ Urinary difficulties
____ Prostatic problems

FEMALES ONLY:

____ Chronic vaginal infections
____ Currently pregnant
____ Currently taking oral contraceptives
Date of last menses_____

CANCER(S): *(LIST TYPE, DATE, TREATMENT)*

_____

_____

DO YOU HAVE ANY FAMILY HISTORY OF SKIN CANCERS/MELANOMA?_____

PATIENT INFORMATION FORM

THE PRACTICE FINANCIAL POLICY WILL BE GIVEN TO PATIENTS AT THE TIME OF REGISTRATION. ALL PATIENTS MUST SIGN THIS FORM.

OUR PRACTICE FINANCIAL POLICY

The physicians and staff at our office are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we accept Visa, MasterCard, American Express, Discover, Cash and Personal checks.

YOUR INSURANCE

We have made prior arrangements with some insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The copayment will be collected when you arrive for your appointment. In the event your health plan determines a service to be Anot covered@, you will be responsible for the complete charge. In that event, you will receive a statement at the time of service and payment is due at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare a statement for you to attach to your insurance claim form for processing of payment. In this case, the insurance carrier will send the payment directly to you. Therefore, charges for your care and treatment are due at the time service is rendered.

Any balance due is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, we ask that you please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its items. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

(Signature of the Patient or Responsible Party) *(Date)*

_____

(Please Print the Name of the Patient)