

**PATIENT INFORMATION Today’s Date:**

 **/ / M / F**

**Full Name (Last, First, MI, “Nickname”) Date of Birth Sex**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ ZIPCODE\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: \_\_ M \_\_S \_\_Divorced \_\_Separated \_\_ Widowed**

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_**

 **REASON FOR VISIT**

**Concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Body Part: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I.D. and Insurance Cards:**

**Primary holder of insurance (If different from patient):**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s signature or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

**Select past and present medical conditions you have experienced:**

 **None Atrial Fibrillation Hepatitis Hyperthyroidism**

 **Anxiety Bone Marrow Transplant Hypertension Hypothyroidism**

 **Arthritis Depression HIV/AIDS Stroke**

 **Asthma Diabetes High Cholesterol Gastroesophageal reflux disease**

**Cancers other than skin: Include type/location and treatment(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST SURGERIES**

 **None OR List all past surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SKIN DISEASE HISTORY**

 **None If you have had any of the following skin conditions, provide details below (including treatment dates and location(s)):**

 **Basal Cell Carcinoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acne \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Melanoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dry skin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Precancerous Moles \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eczema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Squamous Cell Carcinoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Psoriasis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Additional Skin Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you wear Sunscreen? Yes No Tanning salon usage? Yes No**

**Do you have a family history of Melanoma? No Yes If yes, which relative(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS**

**List all medication names and dosages including prescription creams, over the counter, and herbal supplements.**

**Have you been FULLY VACINATED for Covid-19? Yes No**

 **No current medications**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES**

**List all allergies and reaction(s), including medication, food, and environmental.**

 **No known allergies**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

**TOBACCO USAGE**

 **None Former Current If a smoker, number of packs per day: \_\_\_ Total years smoking: \_\_ Tobacco Type: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALCOHOL USAGE**

 **NONE Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day**

**OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AGE 65+ ONLY (SKIP THIS SECTION IF YOUNGER THATN 65)**

**Have you ever received a pneumonia vaccination? Yes No**

**Year of most recent pneumonia vaccination: \_\_\_\_\_\_ Vaccination(s) received (check all that apply):**

 **PPSV23 PCV13 Unsure**

**Have you ever received the shingles vaccination(s)? Yes No**

**Do you have an advance care plan/living will? Yes No Decline to specify (If no or decline, continue to next section)**

**Do you have a healthcare proxy? Yes No Designee’s Name/Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Which statement(s) reflect your wishes: Do not intubate Do not resuscitate Full cardiopulmonary resuscitation**

**Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**** [www.cliffsideskinandlaser.com](http://www.cliffsideskinandlaser.com)

**email: cliffside.skin.laser@gmail.com**

**Financial Policy**

**Assignment of Benefits: I hereby authorize the Medical Staff of Cliffside Skin and Laser to render treatment to me/my dependents. I assign and authorize payment of medical/surgical benefits directly to Cliffside Skin and Laser.**

**Financial Policies: I understand that any unpaid balances or non-covered services will be my responsibility. I understand that if I provide incorrect or expired insurance information, I will assume full financial responsibility for all charges incurred. I understand that if my copay is not paid at the time of service, I will receive a bill in the mail to my residence. I understand there will be a $15.00 fee for any all returned checks. We accept cash, checks, MasterCard, Visa, American Express, Apple Pay and Google Pay as forms of payments.**

**By my signature, I certify that the information reported with regard to m insurance coverage is correct and acknowledge that I have read and understand the above financial and cancellation policies (if patient is a minor, signature of responsible party):**

**Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPPA/Patient Consent Form**

**Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Cliffside Skin and Laser provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the office.**

**You have the right to request restrictions on how your protected health information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to the restrictions.**

**By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.**

**The patient understands that:**

* **Protected health information may be disclosed or used treatment, payment, or health care operations.**
* **Cliffside Skin and Laser has a Notice of Privacy Practices that the patient has the opportunity to review at any time. A copy of this Notice may be requested in person, by mail, or by phone during normal business hours.**
* **The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.**
* **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.**

**Informed Patient Consent:**

* **I give my permission to Cliffside Skin and Laser and staff to treat me, including any biopsy or procedures, as deemed necessary within their professional judgment.**
* **I authorize Cliffside Skin and Laser to take photographs for the clinical record.**
* **I understand the photographs obtained is the sole property of Cliffside Skin and Laser and may include appropriate portions of the body to demonstrate the surgery/procedure. Every effort will be made to protect the patient’s identity in those materials.**
* **I authorize Cliffside Skin and Laser to release any information, including the diagnosis and the records of any treatments or examinations rendered to me or my child during period of such medical care. I also authorize the release of my medical records to third-party payers including Medicare and Medicaid.**

**By signing below, I acknowledge that I have read and understand all of the above statements**

**Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Guardian for Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**