



Please be sure to fill out all information and sign. Payment is expected at time of service. If you have any questions, please speak with the receptionist. Thank you.

\*\*Any record requested or sent by other Physicians will not be stored/kept in our office.

**Patient Registration**

Today's Date: \_\_\_\_\_

Name (First, Middle, Last): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: (M) (F) Marital Status: (S) (M) (D) (W)

Email: \_\_\_\_\_

Are you of Hispanic or Latino decent? (Yes) (No) If yes, from what region? \_\_\_\_\_

**\*\*Please circle the below number at which you would prefer us to leave messages.\*\***

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

**Do we have permission to?**

- Discuss your medical condition with a family member? Yes No
- Leave a message with Pathology/Lab results? Yes No
- Permission to send appointment reminders by email? Yes No
- Permission to access your medication list from the national database? Yes No

**Emergency Contact Information**

Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

**If Minor**

Parent/Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Occupation \*If minor provide parents\***

Position: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PLEASE TURN OVER →**

### Referring/Primary Doctor

Primary/Referring Physician: \_\_\_\_\_

### Primary Health Insurance Information

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Patient's Relationship to Insured Party: (Self) (Spouse) (Child) \*SSN is required for Primary Holder\*

Name of Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### Secondary Insurance Information:

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Patient's Relationship to Insured Party: (Self) (Spouse) (Child)

Name of Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### How did you hear about us?

Doctor: \_\_\_\_\_ Insurance: \_\_\_\_\_ Patient: \_\_\_\_\_ Other: \_\_\_\_\_

### Pre-Authorized Healthcare Form

I authorize Davidson Dermatology to keep my signature on file and to charge my credit card account as indicated below:

Check one:  MasterCard  Visa  Discover  American Express

Balance of charges not paid by insurance within 90 days and not to exceed \$ \_\_\_\_\_

this visit only

all visits this year

Recurring charges (on-going treatments) of \$ \_\_\_\_\_ every \_\_\_\_\_ from to \_\_\_\_\_ / \_\_\_\_\_.

(frequency) (date) (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid unless I cancel the authorization through written notice to the healthcare provider.

Patients Name: \_\_\_\_\_ Cardholder Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Expiration (Month/Year): \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please sign even if you do not provide credit card.

## **HEALTH INFORMATION**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

### **Reason for Visit**

What brings you to the office today?

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### **What cosmetic services are you interested in?**

- Facial Fillers     Sculptra     Neurotoxin (Botox, Xeomin, Dysport)     Revision Skin Care  
 Laser Skin Treatments     Laser Hair Removal     Sunscreens     Make-up, Jane Iredale

### **Review of Systems**

Check those that apply:

- Bleeding Disorder Describe: \_\_\_\_\_  
 Pacemaker or Implanted Device Describe: \_\_\_\_\_  
 Do you require antibiotics prior to dental procedures due to a heart murmur?  
 Pregnant  
 Nursing  
 Trying to conceive

### **Past Medical History**

Have you ever had any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Acne  | <input type="checkbox"/> Keloid/Hypertrophic Scar        |
| <input type="checkbox"/> Actinic Keratosis   | <input type="checkbox"/> Loss of toe, foot, ankle or leg |
| <input type="checkbox"/> Arrhythmia  | <input type="checkbox"/> Mood Disorder                   |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Obesity                         |
| <input type="checkbox"/> Atopy-Allergies or Atopic Dermatitis                      | <input type="checkbox"/> Psoriasis                       |
| <input type="checkbox"/> Atypical Nevi   | <input type="checkbox"/> Rosacea                         |
| <input type="checkbox"/> Chronic Kidney Disease                                    | <input type="checkbox"/> Shingles                        |
| <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease)              | <input type="checkbox"/> Skin Cancer:                    |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Unknown                         |
| <input type="checkbox"/> Drug Dependency   | <input type="checkbox"/> Basal Cell Carcinoma            |
| <input type="checkbox"/> Heart Failure   | <input type="checkbox"/> Squamous Cell Carcinoma         |
| <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Melanoma                        |
| <input type="checkbox"/> Herpes Simplex Virus                                      | <input type="checkbox"/> Merkel Cell Carcinoma           |
| <input type="checkbox"/> High Blood Pressure                                       |  |
| <input type="checkbox"/> HIV   |  |
| <input type="checkbox"/> Immune Disorder such as rheumatoid or psoriatic arthritis |  |

### **Family History**

Has anyone in your family ever had any of the following conditions?

- Unknown-Adopted  
 Atopy- Asthma, Allergies or Atopic Dermatitis  
 Autoimmune Disorders  
 Diabetes  
 Psoriasis  
 Skin Cancers:
  - Unknown Type
  - Basal Cell Carcinoma
  - Squamous Cell Carcinoma
  - Melanoma
  - Merkel Cell Carcinoma

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**Family History continue...**

Any other family history that you think we should know of?

Details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Lifestyle Factors**

Have you ever smoked? Yes No # of years \_\_\_\_\_ # of packs/day \_\_\_\_\_

Do you smoke now? Yes No

How much alcohol do you drink per week? # drinks/week \_\_\_\_\_

**Current Medications**

ALL medications including over the counter and/or supplements?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Are you allergic to any of the following?

Lidocaine Latex Adhesive Tape

Please list any and all allergies to medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Vaccinations**

Influenza Immunization? Yes No If yes: date: (Month/Year) \_\_\_\_\_

Pneumococcal Vaccination? Yes No If yes: date: (Month/Year) \_\_\_\_\_

**Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_

**Insurance Preferred Laboratory:**

\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Medical Assistant:** \_\_\_\_\_