SKIN LASER & SURGERY SPECIALISTS

OF NEW YORK AND NEW JERSEY

www.skinandlasers.com

20 Prospect Ave, Suite 702	115 East 57th, Suite 710	4800 N Federal Hwy, C101	105 Raider Blvd, Suite 203
Hackensack, NJ 07601	New York, NY 10022	Boca Raton, FL 33431	Hillsborough, NJ 08844
201-441-9890	212-750-8900	561-886-0970	908-359-8980
201-441-9893 Fax	212-750-4838 Fax		908-281-7796 Fax

PATIENT INFORMATION

Today's Date________________ Date of Birth___________________________ Age ________________________

Patient ____
Last Name First Name Middle Initial

Social Security #____________________________ Sex □M □F Marital Status: □S □M □D □W

Address ____
Street City State Zip

Home Phone #_____________________ Business #________________ Cell_____________________ E-mail __________________

Emergency Contact: _________________________ Relationship: ____________________ Phone: _________________________________

I give permission to give medical information to: ________________________________ Patient initial: ____________________

I give permission to leave NORMAL results on voice mail/ to person answering phone. Patient initial: ______________________________

INSURANCE INFORMATION

Primary Insurance___________________________ID#__________________________________Group # ________________________

Subscriber's Name____DOB_________________Relationship ________________________

Subscriber's Address ____ Subscriber's Social Security #____________________________

EmployerName/Address____

Secondary Insurance________________________________ID#________________________________Group # ______________________

Subscriber's Name____ DOB_________________ Relationship ________________________

Family Physician____
Name Address Phone #

How Did You Hear Of Us?

Friend□ Our Website□ Internet□ Princeton Mag.□ Yellow Pages □ (201) Magazine□ Beauty Mag□ T.V. □ Other □___________________

Referred by MD ____
Name Address Phone #

I hereby authorize Skin Laser & Surgery Specialists of New York & New Jersey, L.L.C. to release to my insurance carrier any medial information necessary for the completion of my medical claim. I understand that this may include copies of my medical records or lab results.

GUARANTEE TO PAY

I authorize payment of my medical benefits for treatment and/or surgery directly to Skin Laser & Surgery Specialists of New York & New Jersey, L.L.C. I understand that any outstanding balance not covered or paid by my insurance, in addition to all consultation fees, will be my responsibility to pay. If my account is turned over to an attorney or collections agent to obtain payment, then I shall be responsible for the attorney's fee, court costs, and any other costs incurred by the collection agency.

I understand that any cosmetic procedure is payable on the day of service and that in New Jersey 6% tax is required by the state. I realize there is a fee for a consultation. A copy of my signature shall have the same force and effect as the original. I understand and agree that ongoing treatments will be automatically charged to my credit card on the day of procedure. I confirm the above information is accurate.

Skin Laser and Surgery Specialists of NY & NJ, L.L.C. does not honor ADVANCE DIRECTIVES.

____

Signature of Patient or Parent (if minor) Date

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Patient Name: ____________________ Age__________ Date: ________________

Reason for today's visit: ____

____

Allergies to Medication: ____

____

Current Medications (Prescription, Over the Counter, vitamins, herbal supplements): ______________________

____

Please CIRCLE ALL answers and explain:

Patient/Family/Social History

Occupation: ____

Do you live alone?		YES NO	
Do you faint easily?		YES NO	
Are you pregnant?		YES NO	
Trying to become pregnant?		YES NO	
Nursing?		YES NO	
Do you bruise easily?		YES NO	
Do you take aspirin or blood thinners?		YES NO	
Have you ever had a reaction to local anesthetics?		YES NO	
Do you take antibiotics before dental work?		YES NO	
Do you have trouble healing?		YES NO	
Do you develop Keloids?		YES NO	
Have you had skin reactions to:	Medications	YES NO	
	Food	YES NO	
	Environment	YES NO	
	Bandages	YES NO	
Do you smoke?	YES NO	Amount: ________________	
Drink alcohol?	YES NO	Frequency:________________	
Recreational drugs?	YES NO	Type: ________________	
Have you had Skin Cancer?	YES NO	Type: ________________	
Other Cancer?	YES NO	Explain: ________________	
Family History of Melanoma?	YES NO	Explain: ________________	

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Review of Systems

Skin Problems: NONE Eczema / Psoriasis / Vitiligo / Hair or Nail Changes / Sweating Problems
Other: ______________________________
Cardiac Disorders: NONE High B/P / MVP / other:______________________________
Vascular Problems: NONE Edema / Varicose Veins / Bleeding Disorders Other: ______________
Lung Disease: NONE Asthma / Emphysema / Tuberculosis / Other: ______________
Neurological Disorders: NONE Headaches / Seizures / Other:______________
Eye, Ear, Nose, Throat Problems: NONE / Other:______________
GI/GU - Stomach, Intestines, Kidneys: NONE / Other:______________
Musculoskeletal, Artificial Joints, Arthritis: NONE / Other: ______________
Thyroid disease, Diabetes, Lupus, Auto Immune; NONE / Other: ______________
Psychological Disorders: NONE / Other:______________
HIV, AIDS, Hepatitis, Communicable Diseases: NONE / Other:______________
Have you been diagnosed with MRSA: YES NO
Other Important History: ______________
Generally Healthy: YES NO

SIGNATURE: ______________________________ DATE: ______________

PRINT NAME: ______________________________
Completed by: Patient / Parent / Guardian

----------To be filled out by office staff only----------

Past/ Family/ Social History/ System Review Checked by MD: YES NO
Fitzpatrick Skin Type: I II III IV V VI
General Appearance: Clean / Well Nourished / Other: ______________
Mood: Pleasant / Anxious / Confused / Other: ______________
MA/Nursing NOTES (including location, duration, symptoms, other): ______________
____
____
____
____
____

MA/Nurse signature: ______________________________ Date:______________

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