PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Patient Name: _____ **DOB:** _____ Age: ____ Sex: M or F
Home Address: _____ Apt #: _____ **Social Security #:** _____
City: _____ State: _____ Zip: _____ Marital Status: _____
Home Phone: ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____
Patients Employer: _____ Occupation: _____
E-Mail Address: _____

Spouse's Name: _____ DOB: _____ Age: ____
Social Security #: _____ Work Phone: ( ) _____ Cell: ( ) _____
Spouse's Employer: _____ Occupation: _____

PARENT / RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Mother's Name: _____
Social Security #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ Phone #: ( ) _____
Occupation: _____

Father's Name: _____
Social Security #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ Phone #: ( ) _____
Occupation: _____

INSURANCE INFORMATION (PLEASE BRING CARD TO WINDOW)

Primary Insurance: _____
Claiming Mailing Address: _____
Policy #: _____ Group #: _____
Phone #: ( ) _____
Name of Insured: _____
DOB: _____

Secondary Insurance: _____
Claiming Mailing Address: _____
Policy #: _____ Group #: _____
Phone #: ( ) _____
Name of Insured: _____
DOB: _____

Patient Referred: _____
Nearest Friend / Relative (**NOT** living with you): _____ Phone #: ( ) _____
Address: _____ City: _____ State: _____ Zip: _____

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INSURANCE ASSIGNMENT AND MEDICAL RELEASE:

I, the undersigned, do hereby authorize my insuance carrier(s) to pay directly to Lux Dermatology LV, the insurance benefits, if any otherwise **payable to me** for services rendered. I understand that I am financially responsible for any charges not covered by set insurance carrier(s), including co-pay and/or deductible amounts. I, the undersigned, do hereby also give my permission to Lux Dermatology LV, to furnish my insurance carrier(s) any and all information pertaining to my medical records.

_____ _____
Signature of Patient or Authorized Representative: Date:

Patient Name: _____ DOB: _____

Preferred Language: _____ Race: _____

Ethnic Group: ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Unknown ☐ I choose not to specify

Pharmacy (Name/Cross Street/Phone#): _____

Primary Care Provider: _____

Past Medical History: (please circle all that apply)

Anxiety	Colon cancer	GERD	Hypothyroidism	Stroke
Arthritis	COPD	Hearing loss	Leukemia	
Asthma	Coronary artery disease	Hepatitis	Lung cancer	
Atrial fibrillation	Depression	HIV / AIDS	Lymphoma	
Bone marrow transplant	Diabetes	High Cholesterol	Prostate cancer	
BPH	Elevated Blood Pressure	Hyperthyroidism	Radiation treatment	
Breast cancer	End stage renal disease		Seizures	

Other: _____

Past Medical History: (please circle all that apply)

Appendix removed	Biological valve replacement	Liver transplant
Bladder removed	Mechanical valve replacement	Ovaries removed: endometriosis, cancer, cyst)
Breast Biopsy (right, left, bilateral)	Heart transplant	Pancreas removed
Lumpectomy (right, left, bilateral)	Hip replacement (right, left, bilateral)	Prostate removed: (cancer, TURP)
Mastectomy (right, left, bilateral)	Knee replacement (right, left, bilateral)	Prostate Biopsy
Colectomy	Kidney biopsy	Spleen removed
Colostomy	Kidney removed (right, left, bilateral)	Testicles removed (right, left, bilateral)
Gallbladder removed	Kidney stone removal	Hysterectomy (fibroids, uterine cancer, cervical cancer)
Coronoary artery bypass	Kidney transplant	Tubal Ligation

Other: _____

Skin Disease History: (please circle all that apply)

Acne	Blistering sunburns	Hay fever / allergies	Psoriasis
Actinic keratosis	Dry skin	Melanoma	Squamous cell skin cancer
Asthma	Eczema	Poison Ivy	
Basal cell skin cancer	Flaking / itchy scalp	Precancerous moles	

Other: _____

Do you wear sunscreen? ☐ YES ☐ NO Do you tan in a tanning salon? ☐ YES ☐ NO

If yes, what SPF: _____

Do you have a family history of malignant melanoma? ☐ YES ☐ NO

If yes, which relative(s): _____

**Please include any birth control, herbals, vitamins and supplements

Medications (please list all current medications):

_____ _____

_____ _____

_____ _____

_____ _____

☐ No medications

Drug Allergies (please list all current medications):

_____ _____

_____ _____

_____ _____

_____ _____

☐ No known drug allergies

Social History:

Smoking status:

- ☐ Every day smoker
- ☐ Some day smoker
- ☐ Former smoker
- ☐ Never

Alcohol use:

- ☐ None
- ☐ < 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 of more drinks per day

Occupation:

_____

_____

_____

_____

Alerts (please circle all that apply):

Year (____)

Allergy to adhesive	Artificial joint replacement	MRSA
Allergy to latex	Blood thinners	Pacemaker
Allergy to lidocaine	Defibrillator	Require antibiotics prior to procedure
Artificial valve replacement	Keloid scarring	Rapid heart beat with epinephrine

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? ☐ YES ☐ NO

Last menstrual period: _____ (regular/irregular)

Review Of Systems: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Problems with bleeding?		
Problems with healing?		
Problems with scarring?		
Any current rashes?		

LUX DERMATOLOGY

An Affiliate of Artius Dermatology Associates, PC

Cancellation Policy / No Show Policy
For Doctors, Cosmetic & Surgery Appointments

1. Cancellation / No Show Policy for Doctors' Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. Cancellation / No Show Policy for Cosmetic Appointments

We recognize the time of our clients and staff is valuable and have implemented this policy for this reason. When you miss an appointment with us, we not only lose your business, but also the potential business of other clients who could have schedule an appointment for the same time.

Any cancellations with less than 24 hours of notice are subject to a fifty dollar ($50) cancellation fee. Patients who miss their appointments without giving any prior notice will be charged the entire amount of their deposit.

3. Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 48 hours in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance company.

4. Schedule Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

_____ _____ _____

Patient Name **Patient / Guardian Signature** **Date**

Patient Account # _____

(Office Use Only)

MIPS PATIENT INTAKE FORM

Due to requirements from the U.S. Department of HHS, please answer the following questions.

Name: _____ DOB:_____ Email: _____

Do you have any of the following conditions:

Height:_____
Weight:_____

- ☐ Coronary Aretery Disease
- ☐ Chronic Obstructive Pulminary Disease (COPD)
- ☐ Diabetes
- ☐ Heart Failure
- ☐ High Blood Pressure (Hypertension)
  - Most recent blood pressure reading : _____ / _____

Last date you saw your Primary Care Provider: _____

Melanoma:

Have you ever been diagnosed with Melanoma? ☐ YES ☐ NO

If YES, did you ever have a chest X-ray, CT,Ultrasound, MRI, or PET? ☐ YES ☐ NO

Tobacco Use:

Please choose the option that best describes your tobacco use:

☐ Never ☐ Current every day Smoker ☐ Current some day smoker ☐ Former Smoker

For **current tobacco users**, select the option that best describes use:

☐ 1-3 cigarettes per day ☐ Up to 1 pack per day ☐ 1-2 packs per day ☐ 2 or more packs a day

Alcohol Use:

How often do you have an alcoholic beverage?

☐ Never ☐ Less than one drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Vaccinations:

Between October 1st, 2020 and Today, did you receive the following vaccinations?

Flu Vaccine: ☐ YES ☐ NO

Pneumonia: ☐ YES ☐ NO

65 & over

Do you have one of the following?

☐ Power of Attorney (Surrogate Decision Maker) Name/Relationship_____ ☐ Living Will (Advance Care Plan) ☐ None