

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

INSURANCE INFORMATION (PLEASE BRING CARD TO WINDOW)

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

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

INSURANCE ASSIGNMENT AND MEDICAL RELEASE:

I, the undersigned, do hereby authorize my insurance 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 | Leukemia |
| Arthritis | COPD | Hearing loss | Lung cancer |
| Asthma | Coronary artery disease | Hepatitis | Lymphoma |
| Atrial fibrillation | Depression | HIV / AIDS | Prostate cancer |
| Bone marrow transplant | Diabetes | High Cholesterol | Radiation treatment |
| BPH | Elevated Blood Pressure | Hyperthyroidism | Seizures |
| Breast cancer | End stage renal disease | Hypothyroidism | Stroke |

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): _____

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):

Allergy to adhesive

Allergy to latex

Allergy to lidocaine

Artificial valve replacement

Artificial joint replacement

Blood thinners

Defibrillator

Keloid scarring

MRSA

Pacemaker

Require antibiotics prior to procedure

Rapid heart beat with epinephrine

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? YES NO

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?		



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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:

- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Heart Failure
- High Blood Pressure (Hypertension)
 - o 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