

Medical History:

Last Name: _____ First Name: _____

DOB: _____ Sex: _____ PCP: _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: (H) _____ (C) _____

Emergency Contact: _____

Please answer all of the following questions:

1. Please list any current or chronic medical conditions: _____

2. Please list all Surgery you have had: _____

3. Please list ALL medications (prescribed and over the counter), vitamins, and herbal medicines you take: _____

4. Please list all medication allergies: _____

5. Women – Are you pregnant? _____ When was your last period? _____

6. How did you hear about us? _____

7. To help us determine your skin type, please circle the statement below that best describes you:

<u>Type</u>	<u>Reaction to initial sun exposure yearly</u>
1	Always burn, never tan
2	Usually burn, tan with difficulty
3	Sometimes burn, tan average
4	Rarely burn, tan easily
5	Rarely burn, tan very easy
6	Never burn, always tan

Please answer the following questions: If you answer “Yes” to any question, please circle condition.

Yes	No	Is your skin sensitive to the sun?
Yes	No	Since starting or changing medication have you noticed increased sensitivity to the sun?
Yes	No	Have you taken or do you take Accutane, anticoagulants (blood thinners), antibiotics, anti-depressants, St. John’s Wort, Retin-A (Retinoic Acid)?
Yes	No	Do you have a history of cold sores or Herpes?
Yes	No	Do you have history of migraines, seizure disorder, coronary heart disease, Lupus, any disease causing immunosuppression or diabetes?
Yes	No	Do you have a history of eczema, psoriasis, rashes, etc?
Yes	No	Do you have a history of abnormal pigmentation (light or Darker areas) and/or scarring (for example keloids) after previous surgery or injury?
Yes	No	Do you have a personal or family history of abnormal moles or skin cancer?
Yes	No	Have you ever had a facial peel, laser treatment, dermabrasion, fillers (i.e. collagen injection), sclerotherapy or other plastic surgery?
Yes	No	Has there been scarring, from any cause, in the area to be treated?
Yes	No	Have you been in the sun, or used a self tanner or bronzer recently? If so, when?
Please check all methods you have use in the past for hair removal: Laser _____ Waxing _____ Electrolysis _____ Shaving _____ Tweezing _____ Depilatory _____		

What service(s) may we provide for you today or in the future? _____

By signing below, I agree that the above noted information is correct to the best of my knowledge. I am aware that it is my responsibility to inform the practitioner of my current medical or health conditions with each treatment, should they change from the time of consultation.

Patient Signature

Date

MD/NP/RN

Date

ACKNOWLEDGEMENT OF RECEIPT OF MICHAEL REINHORN, M.D., P.C.'S PRIVACY NOTICE, COMMUNICATION AUTHORIZATION AND PAYMENT POLICY

I have been present with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I have been presented with a Communication Authorization relating to how communications may be handled on my behalf. I have also been presented with a Payment Policy outlining the billing practices and my responsibilities for any non-covered services.

Initial:_____ Self Other_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY OR FRIEND

I hereby authorize my physician to release my medical information including tests and biopsies to:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

COMMUNICATION AUTHORIZATION

We would like to be able to communicate with you as promptly as possible and would like your approval for the following:

- 1. If you are employed, may we call you at work? Yes No Not Applicable
- 2. If you have an answering machine, may we leave you a message? Yes No
- 3. If we call your home and you are not there, do we have permission to speak with family members listed above? Yes No
- 4. May we contact you by email for appointment reminders or special promotions? Yes No

SIGNATURE REQUIRED

Patient Signature:_____ Date_____

Relationship if other than Patient_____