COSMETIQUE DERMATOLOGY, LASER & PLASTIC SURGERY LLP

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Thank you for taking the time to complete these forms. This very important information is confidential and will remain in your chart. Once you have completed filling-out the **front** and **back** of this form, please return it to the receptionist. Thank you.

Today's Date: ________________________

PATIENT'S PERSONAL DATA

NAME: ____

ADDRESS: ____

CITY: _________________________ STATE: _____________ ZIP: _________________________

HOME PHONE: _____–__________ WORK: _____–__________ CELL PHONE: ____-____________

SSN#: _____-_____-________ DATE OF BIRTH: ___/___/____ AGE: ________________________

E-MAIL:_______________________________________ REFERRED BY: ________________________________

REFERRING MD ADDRESS: ____

CITY: _________________________ STATE: _____________ ZIP: _________________________

FAMILY DOCTOR: ____ PHONE: ____-_________________

ADDRESS / CITY / STATE / ZIP: ____

PHARMACY NAME: ____ PHONE: _____-_______________

PHARMACY ADDRESS: ____

PATIENT'S BUSINESS DATA

EMPLOYER: _______________________ OCCUPATION: ________________________ PHONE: ____-____________

ADDRESS: _______________________________________ CITY / STATE / ZIP CODE: _________________________

SPOUSE / PARENT / NEAREST RELATIVE / FRIEND / EMERGENCY CONTACT

NAME: _____________________________________ RELATIONSHIP TO PATIENT: ___________________________

ADDRESS: __________________________________ CITY / STATE / ZIP CODE: ______________________________

HOME / CELL PHONE: _________________________ OCCUPATION: _______________________________________

EMPLOYER: _________________________________ BUSINESS PHONE: ___________________________________

BUSINESS ADDRESS / CITY / STATE / ZIP: ____

INSURANCE INFORMATION **Please present your current insurance card(s) and any referral information, if applicable, to the receptionist. Thank you.**

PRIMARY INSURANCE: _____________________ POLICY HOLDER'S NAME: ________________ ID #: ______________________

SECONDARY INSURANCE: __________________ POLICY HOLDER'S NAME: ________________ ID #: ______________________

POLICY HOLDER DATE OF BIRTH: _____________________

REASON FOR CONSULTATION ____

Signature ____ **Date** ____________________________

MEDICAL HISTORY QUESTIONNAIRE

Are you currently under the care of, or have you ever been treated by, a physician for any of the following illnesses ? Diabetes, High blood pressure, Heart or Blood vessel disease, Kidney disease, TB or Lung disease, Ulcer disease, Anemia or Bleeding disorders, Hepatitis, Emotional or Psychiatric disorders, Immune disorders or AIDS, Skin cancer, Malignant melanoma, Other types of cancer or malignancies. Please circle and elaborate below:

____

____

____

Have you ever been hospitalized or had any surgery? If so, please list the following:

Date(Year)	Hospitalization or type of surgery	Name of Doctor	Hospital

HEIGHT ____________ WEIGHT ______________ Is your weight stable? YES NO

Do you have any **allergies to medications**? (Please circle response)

PENICILLIN OR OTHER ANTIBIOTICS YES NO

LOCAL ANESTHESIA YES NO

OTHER MEDICATIONS YES NO

If yes, please list:____

Do you have any bleeding tendencies? YES NO

Are you presently taking, or have you taken within the past month, any medications?

ASPIRIN YES NO
(or any aspirin-containing over-the-counter medications)

ORAL CONTRACEPTIVES YES NO

BLOOD THINNERS YES NO

ANY OTHERS YES NO
(If yes, please list below)

NAME OF MEDICATION 1 ___________________________ 2. _____________________________

DOSAGE & FREQUENCY ___________________________ _____________________________

Do you smoke cigarettes? YES NO

If yes, how many packs per day? _______________ For how many years? ____________________

Do you drink alcoholic beverages daily or frequently? YES NO

Please bring to the doctor's attention any history of controlled substance use for medical or recreational purposes.

Signature ____ **Date** ___________________________