Laub

DERMATOLOGY & AESTHETICS

EXPERTISE • ARTISTRY • WELLNESS™

PATIENT INFORMATION

Date _____ (MM/DD/YYYY) ❑ Male ❑ Female Date of Birth _____ (MM/DD/YYYY) Age _____ Social Security # _____

Patient Name _____ (LAST) _____ (FIRST) _____ (M.I.) Nickname _____ Phone _____

Work Phone _____ Mailing Address _____ City _____

State _____ Zip _____ E-Mail _____

❑ Please check here if you do not want notifications or practice updates via e-mail.

Marital Status _____ Occupation _____ Employer _____

In Case of Emergency Notify _____ Phone _____

INSURANCE INFORMATION

Name of Insured Subscriber (Guarantor) _____ (LAST) _____ (FIRST) _____ (M.I.) Subscriber's Date of Birth _____ (MM/DD/YYYY)

Complete mailing address of guarantor if different from above:

Mailing Address _____ City _____ State _____ Zip _____

Phone _____ Insurance Carrier _____

Group/Plan Number _____ ID Number _____ Insurance Carrier's Phone _____

Claim Address _____ City _____ State _____ Zip _____

Assignment and release: I hereby authorize my insurance benefits to be paid directly to my physician David Laub, M.D. (APC). I understand I am financially responsible for non-covered services and also authorize my physician to release any information requested by my insurance company.

If patient is a minor, name of parent or legal guardian _____ (LAST) _____ (FIRST) _____ (M.I.)

The adult/guardian who brings the child will be responsible for all copayments and deductibles. We do not forward bills to other parties. Guarantor insurance information above must be completed.

Signature _____ (IF MINOR IS A PATIENT, SIGNATURE OF PARENT OR LEGAL GUARDIAN) Date _____ (MM/DD/YYYY)

Notice of privacy practice: with my consent, David A. Laub M.D. (APC) including his staff, may phone or/fax a designated location, and leave a message on voice mail, or in person, in reference to any item that assists the practice in carrying out treatment, payment, and healthcare operations. This may pertain to, but is not limited to the following: appointment reminders, clinical care, and insurance items. I understand that I may request to review the notice of privacy practice information for David A. Laub M.D. (APC). For a complete HIPAA Privacy Policy please see our HIPAA Notice.

❑ YES ❑ NO I authorize Laub Dermatology & Aesthetics and staff to leave a message regarding my protected/private health information on this phone number only: _____

❑ YES ❑ NO I authorize Laub Dermatology & Aesthetics and staff to speak to or leave a message with the person named below regarding my protected/private health information.

Patient's Name _____ (LAST) _____ (FIRST) _____ (M.I.) Phone _____

Signature _____ Date _____ (MM/DD/YYYY)

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PATIENT REFERRAL INFORMATION

Primary Care Physician Name _____ Phone _____ Fax _____

If you were referred by a friend may we thank him or her? ❑ YES ❑ NO Friend's Name _____ _____
LAST FIRST

How did you learn about our office? ❑ Doctor ❑ Internet/Website ❑ Insurance ❑ Yelp ❑ Other _____

PATIENT HISTORY

Patient Name _____ _____ _____ Date of Birth _____
LAST FIRST M.I. MM/DD/YYYY

Please list the names of other family members seen by the doctor _____

Reason for today's visit

Preferred Language _____ Race _____ Ethnic Group _____

Pharmacy Name _____ Phone _____ Fax _____

City or Zip Code _____

PAST MEDICAL HISTORY (please check all that apply)

❑ Anxiety
❑ Arthritis
❑ Blood Clots
❑ Coronary Artery Disease Depression
❑ Diabetes
❑ G.I. Ulcers
❑ Glaucoma
❑ Heart Attack
❑ Hepatitis B, C
❑ Irregular Heart Beat Leukemia Lymphoma
❑ Organ Transplantation Phlebitis
❑ Radiation Treatment Seizures
❑ Stomach Ulcers
❑ Stroke
❑ Thyroid Problems
❑ High Blood Pressure
❑ HIV/AIDS
❑ High Cholesterol
❑ Thyroid Problems
❑ Tinnitus
❑ Tuberculosis
❑ NONE
❑ Other _____

PAST SURGICAL HISTORY

Please list all past surgical history

SKIN DISEASE HISTORY (please check all that apply)

❑ Acne
❑ Asthma
❑ Blistering Sunburns
❑ Eczema
❑ Flaking or Itchy Scalp
❑ Hives
❑ Actinic Keratoses
❑ Basal Cell Skin Cancer
❑ Dry Skin
❑ Fever Blister / HSV
❑ Hay Fever/Allergies
❑ Melanoma
❑ Precancerous Moles
❑ Squamous Cell Skin Cancer
❑ Psoriasis
❑ Pigmentation Disorders

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Do you wear sunscreen? ❑ YES ❑ NO If yes, what SPF?

Medications (please list all current medications and dose, vitamins etc)

Allergies (please list all allergies)

PROCEDURE HISTORY (please check all that apply)

If you have had any of these procedures previously or have interest in learning more about the corrective treatments available below, please circle all that apply.

❑ Acne Scarring
❑ Blotchy Skin
❑ Chemical Peels
❑ Laser Treatments
❑ Pigmentation Treatment
❑ Blood Vessel / Rosacea Treatment
❑ Coolsculpting / Fat Reduction
❑ Facial Fillers
❑ Length /Fullness of Eyelashes
❑ Skin Rejuvenation for Aging Skin
❑ Botox / Dysport
❑ Chin / Neck Wrinkles
❑ Hair Removal
❑ Leg Vein Treatment
❑ Skin Care Advice

SOCIAL HISTORY (please check all that apply)

Cigarette Smoking

❑ Currently smokes
❑ Never smoked
❑ Former smoker

Alcohol Use

❑ None
❑ Less than 1 drink per day
❑ 1-2 drinks per day
❑ 3 or more drinks per day

SKIN CARE ROUTINE Please list the skin care products you are currently using. (please check all that apply)

❑ Moisturizer
❑ Acne Treatment products
❑ Antioxidants
❑ Retinoids
❑ Other

Are you currently pregnant? ❑ YES ❑ NO Trying to get pregnant? ❑ YES ❑ NO Currently nursing? ❑ YES ❑ NO

REVIEW OF SYSTEMS (please check all that apply)

❑ Problems with bleeding
❑ Problems with healing
❑ Problems with scarring
❑ Rash
❑ Rapid heartbeat with epinephrine
❑ Immunosuppression
❑ Thyroid Problems
❑ Fever or chills
❑ Joint aches

ALERTS (please check all that apply)

❑ Allergy to Adhesive
❑ Allergy to topical antibiotics
❑ Allergy to Latex
❑ Artificial joint replacement
❑ Defibrillator
❑ Hepatitis A, B, C
❑ MRSA
❑ Require antibiotics prior to a surgical procedure
❑ Fever Blisters
❑ History of Melanoma
❑ Allergy to lidocaine
❑ Allergy to topical anesthetic Artificial Heart Valve
❑ Blood thinners
❑ Faints when given shots
❑ HIV / AIDS
❑ Pacemaker
❑ Rapid heart beat with epinephrine

Do you have a family history of Melanoma ❑ YES ❑ NO If yes, which relative(s)?