Derma Laser Centers

Cosmetic Dermatology and Hair Restoration

PATIENT HISTORY FORM

MERCER COUNTY 609.631.8558 | BERGEN COUNTY 201.840.1210 | SOMERSET COUNTY 732.356.8700 | MONMOUTH COUNTY 732.291.0770

Today's Date ______ Name ______

Address ______ City ______

State ______ Zip Code ______ Driver's License # ______

Social Security # ______ Date of Birth ______

Occupation ______ Employer ______

Emergency Contact ______ Relationship ______ Phone ______

How did you hear about our office? ______

Home # ______ Work # ______

Cell # ______ Email ______

MEDICAL HISTORY

Previous Illnesses or Injuries ______

List Previous Surgeries and Dates ______

Hospitalizations, Diagnoses and Dates ______

Allergies ______

Current Medications ______

What procedure are you interested in? *(If more than one, please number according to priority.)*

____ Acne Scars	____ Botox™	____ Chemical peels	____ Laser hair removal
____ Facial Rejuvenation	____ Sagging (jowling)	____ Fillers	____ Liposuction (SmartLipo™)
____ Mole removal	____ Varicose veins	____ Laser tattoo removal	____ Eyelid surgery
____ Wrinkles	____ Hair Transplant	____ Facial vein removal	____ Plasma resurfacing

If other please specify: ______

When exposed to sun/tanning beds, your reaction is best described as *(please check the best answer.)*

____ Always burn – Never tan	____ Sometimes mild burn – Tan average	____ Rarely burn – Tan with ease
____ Rarely burn – Tan very easily	____ Usually burn – Tan with difficulty	____ Never burn – Tan very easily

Have you seen a dermatologist in the past two years? Yes No

Are you currently under treatment for any condition? Yes No

Please explain: ______

Have you in the past 2 weeks been prescribed any skin creams, lotions or antibiotics? Yes No

Do you smoke? How much per day? Yes No

Do you use any drugs or alcohol? Daily/Weekly/Monthly? Yes No

Who is your primary doctor? ______ Phone: ______

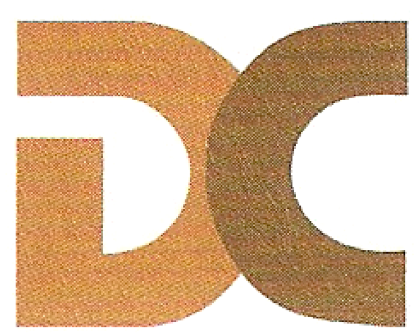
Have you ever been treated for a psychological and/or psychiatric problem? Yes No

Please explain: ______

Hair Color ______ Skin Color ______

I certify that the above information is correct.

Patient Signature ______ Date ______



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I can request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but, if you do agree, you are then bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________