MASTER REGISTRATION

WELCOME! PLEASE COMPLETE ALL INTAKE FORMS IN THEIR ENTIRETY AND PRINT CLEARLY TO AVOID CHECK-IN DELAYS. THANK YOU!

Today' Date _____

Name _____
Last First M.I.

Address_____
Street City State Zip

Home Phone (____)_____-_____Work Phone (____)_____-_____ Cell Phone (____)_____-_____

Date of Birth (DOB) _____ Age _____ Gender _____ SS # _____-_____-_____

Marital Status (circle one): Single Married Divorced Widowed

In case of Emergency, who should be notified?

Name _____ Phone (____)_____-_____ Relationship to the Patient _____

PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name _____ Phone (____)_____-_____

INSURANCE INFORMATION *(Please enter info if you are NOT the primary cardholder.)*

Primary Insurance	**Secondary Insurance**
Insurance Company Name _____	Insurance Company Name _____
Policy Holder _____	Policy Holder _____
Insured DOB _____	Insured DOB _____
Employer Name _____	Employer Name _____
Relationship of patient to the Insured _____	Relationship of patient to the Insured _____

PATIENT PORTAL

A patient portal is a secure online website that provides patients convenient 24-hour access to personal health information, including recent doctor visits, visit summaries, lab results, prescriptions and appointment information. In order to have access to the patient portal, you must provide your email address. At your visit today, you will receive instructions with steps on how to create a username and password to access your personal information on Patient Portal.

Email Address: _____

On occasion you will receive an emailed newsletter with office updates, special announcements, and industry news. We keep your information secure and you will always have the opportunity to unsubscribe from the newsletter.

BACKGROUND

Race
- ▯ American Indian/Alaska Native
- ▯ Asian
- ▯ African American
- ▯ Native Hawaiian
- ▯ White

Ethnicity
- ▯ Hispanic / Latino
- ▯ Non-Hispanic / Latino

Preferred Language
- ▯ English
- ▯ Spanish
- ▯ French
- ▯ Hindi
- ▯ Other _____

(TURN OVER TO BACKSIDE)

HEALTH INFORMATION DISCLOSURE

I allow the staff at Schaumburg Dermatology to discuss my medical and financial issues with the following person(s). This is valid until revocation is given in writing. (If you do not want us to share this information, write "NONE" next to the first Name below.)

Name _____ Phone (____)_____-_____ Relationship to the Patient _____

Name _____ Phone (____)_____-_____ Relationship to the Patient _____

MESSAGES FOR LAB RESULTS

Only select (X) **one** box below. Please read carefully.

☐ I Authorize Schaumburg Dermatology to leave voicemails with details of my appointments and lab results on the following numbers (check all that apply): _____ Home phone ____ Cell phone ____ Work phone

☐ I do not want appointment information and lab results left on voicemails. If this is checked Schaumburg Dermatology staff will only leave a message for you to call our office back.

PARENTAL RELEASE OF MINORS

After the first visit, the parent / legal guardian may provide a signed release that will permit the minor patient to be seen for that same diagnosis or any new complaint without a parent / legal guardian present. If the patient presents with a new diagnosis, the signed release will serve as authorization to discuss and treat the condition with the minor directly. Parents may want to be present for new complaints so they can understand the diagnosis and treatment options directly from our providers. Procedures may require a parent / legal guardian on site

I allow my child, _____ to come for his/her office visits alone unsupervised and will allow for treatment discussion, prescribing of medications, and procedures to be performed as deemed medically appropriate for my child's condition. This authorization will be valid for one year or until revocation is given in writing.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Print Name of Legal Guardian Relationship to patient

ACKNOWLEDGEMENT

I acknowledge that I have read this entire form and have answered all questions truthfully and to the best of my ability.

_____
Signature of Patient or Legal Guardian Date

Patient History Form

Today's Date:

Patient Name: _____ DOB: _____ Age: _____ Gender: _____

Primary Care Physician: _____ How did you hear of us? : _____

Physician address & phone: _____

Local Pharmacy: Name _____Address _____Phone (____)_____-_____

Mail Order Pharmacy: Name _____ Fax (____)_____-_____

Reason for today's visit (chief complaint): _____

PAST MEDICAL/FAMILY HISTORY: Check if you personally or anyone in your family has:

	SELF	RELATIVE		SELF	RELATIVE		SELF	RELATIVE
Allergies	( )	( )	High Cholesterol	( )	( )	Arthritis	( )	( )
Eczema	( )	( )	Lung Disease	( )	( )	Diabetes	( )	( )
Asthma	( )	( )	Skin Cancer	( )	( )	Heart Disease	( )	( )
Hives	( )	( )	Malignant Melanoma	( )	( )	Hypertension	( )	( )
Psoriasis	( )	( )	Other Cancer	( )	( )	Tuberculosis	( )	( )
Pacemaker	( )		Herpes/Cold Sores	( )		Metal implants	( )	

CURRENT OR PAST PROBLEMS WITH (review of systems):

	YES	NO	(If yes, explain)
General Health (i.e. headaches,etc)	( )	( )	_____
Eyes	( )	( )	_____
Ears/Nose/Throat/Mouth	( )	( )	_____
Cardiovascular	( )	( )	_____
Respiratory	( )	( )	_____
Gastrointestinal (stomach/bowel)	( )	( )	_____
Genitourinary (kidneys)	( )	( )	_____
Musculoskeletal (arthritis/muscles)	( )	( )	_____
Skin	( )	( )	_____
Neurological Disorder (seizures,etc)	( )	( )	_____
Psychiatric (anxiety, etc)	( )	( )	_____
Thyroid/Diabetes	( )	( )	_____
Hematology (bleeding disorder)	( )	( )	_____
Allergic/Immunologic	( )	( )	_____

A**LLERGIES** (drug, latex, food, pet): _____

CURRENT MEDICATIONS (list all prescriptions and over the counter medications and supplements)

_____

_____

MAJOR MEDICAL ILLNESS/SURGERIES: _____

_____

Do you drink alcohol? ☐YES ☐NO How often?_____ Do you use smoke? ☐YES ☐NO How often?_____

Occupation: _____ Are you Pregnant? ☐YES ☐NO

Marital Status: ____Married ____Divorced ____Widowed____Single

(TURN OVER TO BACKSIDE)

Dear Patient: Our goal is to respond to all of our patient's needs and to provide the highest quality care. In order to provide the information and services **you desire** on the health and appearance of your skin, please complete the following questionnaire:

Please check all that apply:

- ☐Lines around my eyes
- ☐Lines between my eyes (angry look)
- ☐Lines on forehead
- ☐Puffy eyes
- ☐Sunk in eyes
- ☐Thin lips
- ☐Dry skin
- ☐Oily skin
- ☐Looking tired
- ☐Crease nose to corner of mouth
- ☐Frown on corner of mouth
- ☐Brown spots on face
- ☐Red, blotchy skin
- ☐Excess skin above eyes
- ☐Thin face, no cheeks
- ☐Dimpled chin
- ☐Body/Surgical Scars
- ☐Acne Scars

Procedures or products of interest to you (please check all that apply).

- ☐BOTOX® Cosmetic (Botulinum Toxin Type A)
- ☐Chemical Peels (Salicylic and TCA)
- ☐Removing Facial Veins
- ☐Skin Rejuvenation
- ☐Retinols
- ☐Microdermabrasion
- ☐Laser Resurfacing
- ☐Laser Pigment Removal
- ☐Laser Hair Removal
- ☐Photorejuvenation (IPL)
- ☐Skin Care Advice
- ☐Skin Care Products
- ☐Nonsurgical Skin Tightening
- ☐Liver Spots/Age Spots
- ☐Sunscreen Advice
- ☐Laser therapy for Spider Veins
- ☐Nonsurgical Fat Reduction
- ☐Facials and Eye Treatments
- ☐Dermal Fillers (Restylane, Juvederm)
- ☐Other, please specify _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than True Age				*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my skin.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

If you could improve anything about your appearance what would it be? _____

I would like to schedule a Cosmetic Consultation regarding my above concerns. ☐Yes ☐No

ACKNOWLEDGEMENT

I acknowledge that I have read this entire form and have answered all questions truthfully and to the best of my ability.

_____

Signature of Patient or Legal Guardian Date