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Name: ____ Title: Dr/Mr/Mrs/Ms/Miss
Last First M.I. Circle one

Primary Address: ____
Street # Street name Apt# City State Zip

Out-of-state Address: ____
Street # Street name Apt# City State Zip

Home phone ______________ Cell phone ______________ Preferred phone (circle one): Home, Cell
If my preferred phone is cell, I understand that I may receive text messages for appointment reminders and other notifications.

Email address (will allow you online access to your medical records): ______________________

DOB: ____________ SSN: ______________ Marital Status: Single/Married/Divorced/Widowed

Race: ____________ Ethnicity: Hispanic – Non-Hispanic Sex: ☐ M ☐ F

Primary care physician: ______________________ Phone: ______________

Pharmacy name: ______________________ Pharmacy phone: ______________

Emergency contact: ______________ Phone: ____________ Relationship: ____________

Employer name: ______________________ Phone: ______________

Who can we thank for your referral?
☐ Physician (list name): ______________ ☐ Advertisement (list publication): ______________
☐ Friend (list name): ______________ ☐ Insurance listing ☐ Online search

Policy Holder (person financially responsible if not self, not the main policy holder, or a minor):

Name: ______________________ DOB: ____________ SSN: ______________

Relationship to patient: ______________ Employer: ______________________

The above information is true and current to the best of my knowledge

Signature: ______________________ Date: ____________

Please present insurance cards and ID to Front Desk

LIFETIME SIGNATURE AUTHORIZATIONS

Consent for evaluation and treatment **Initial** ____
I authorize the physicians and assistants of Brilliant Dermatology & Aesthetics to administer medical care as deemed necessary on behalf of myself and/or dependents.

Release of medical records: **Initial** ____
I authorize the release of medical information as necessary in order to process insurance claims, insurance applications and prescriptions, and to my primary care or referring physician.

Assignment of benefits: **Initial** ____
I authorize payment of insurance benefits paid on my behalf be made directly to Brilliant Dermatology & Aesthetics.

Financial responsibility: **Initial** ____
I understand I am personally responsible for all fees for services rendered in the course of treatment to me or my dependent including co-payments, deductibles, coinsurances, cosmetic services and any charges not covered. Payment is required at the time of service unless you are in a prepaid plan in which we participate. Although we do our best to review participation status with your insurance, it is ultimately the patient's responsibility to know the details of their insurance contract. We accept payment in the form of cash, check, or credit card. A $50 return check fee will be charged.

Cancellation Policy **Initial** ____
Please provide 24 hours notice for cancellations. There will be a $50 charge if you fail to show up for your appointment or cancel with less than 24 hours notice.

Laboratory services **Initial** ____
Specimens sent for pathology or laboratory services are billed separately through the respective companies.

Biopsy results **Initial** ____
We notify you of biopsy results within 2 weeks, often sooner. We do not leave biopsy results on answering machines or with persons who are not on your medical release list. If you do not hear from us, please call.

Privacy Notice Acknowledgement **Initial** ____
I certify that I have been given the opportunity to read a copy of the Notice Of Privacy Practices, and may request a copy for my records.

Release of Protected Health Information **Initial** ____
I allow the release of my health information to be shared with the following persons:

Name	Phone	Relationship

Your signature below signifies your understanding of the above authorizations and policies. I permit a copy of this authorization to be used in place of the original.

Signature: ______________________________________ Date: ____________

Medical History

Past Medical History: (please check all that apply)

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplant
- ❑ BPH
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD/acid reflux
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension (high blood pressure)
- ❑ HIV/AIDS
- ❑ High cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Strokes
- ❑ Other___________________
  ____
  ____

Past Surgical History: (please check all that apply)

- ❑ Appendix Removed
- ❑ Bladder Removed
- ❑ Mastectomy (Right, Left, Bilateral)
- ❑ Lumpectomy (Right, Left, Bilateral)
- ❑ Breast Biopsy (Right, Left, Bilateral)
- ❑ Breast Reduction
- ❑ Breast Implants
- ❑ Colectomy: Colon Cancer Resection
- ❑ Colectomy: Diverticulitis, IBD
- ❑ Gallbladder Removed
- ❑ Coronary Artery bypass
- ❑ PTCA (angioplasty)
- ❑ Valve Replacement: mechanical or biological
- ❑ Heart Transplant
- ❑ Joint Replacement Knee(Right, Left, Bilateral)
- ❑ Joint Replacement Hip (Right, Left, Bilateral)
- ❑ Joint Replacement within last 2 years
- ❑ Kidney Biopsy
- ❑ Kidney Removed (Right, Left)
- ❑ Kidney Stone Removal
- ❑ Kidney transplant
- ❑ Ovaries Removed: Endometriosis, Cyst, Cancer
- ❑ Prostate Removed: Prostate Cancer
- ❑ Prostate Biopsy
- ❑ TURP- Prostatectomy
- ❑ Spleen Removed
- ❑ Testicles Removed: (Right, Left, Bilateral)
- ❑ Hysterectomy: Fibroids,Uuterine cancer

Skin Disease History: (please check all that apply)

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaky or Itchy Scalp
- ❑ Hay fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ Do you wear sunscreen?________ If yes, what SPF_________
- ❑ Do you tan in a tanning salon?_____
- ❑ Do you have a family history of Melanoma?______ If Yes, which relative(s)?________________________

Medications: (please list all current medications and supplements)

- ❑ NONE

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____
____
____

Allergies: (please list all allergies and the reaction you get)

- ❑ NONE

____
____

Smoking Status:

- ❑ Current every day smoker
- ❑ Current some day smoker
- ❑ Former smoker
- ❑ Never smoked

Alcohol Status:

- ❑ Alcohol consumption: NONE
- ❑ Less than 1 drink per day
- ❑ 1-2 drinks per day
- ❑ 3 or more drinks per day

Cautions/Alerts: (please check all that apply)

- ❑ Pregnancy or planning a pregnancy
- ❑ Allergy to adhesive
- ❑ Allergy to topical antibiotic ointments
- ❑ Allergy to Lidocaine
- ❑ Rapid heartbeat with epinephrine
- ❑ Premedication prior to procedures
- ❑ Artificial heart valve
- ❑ Artificial joints within past 2 years
- ❑ Blood thinners
- ❑ Defibrillator
- ❑ Pacemaker
- ❑ History of MRSA
- ❑ History of vasovagal ("passing out" after stress)
- ❑ Have you had your pneumonia vaccine? Y/ N
- ❑ Other: ___________________________