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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

Approximate start/end date at out-of-state address: ____________________

DOB: ____________ Last 4 of SSN: ____________ Marital Status: Single/Married/Divorced/Widowed

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

Home phone ____________ Cell phone ____________ Email address: ________________

Primary care physician: ______________________________ Phone: ________________

Pharmacy name: ______________________________ Pharmacy phone: ________________

Emergency contact: ________________ Phone: ____________ Relationship: ____________

Employer name: ______________________________ Phone: ________________

Referred by:
☐ Physician (list name): ________________ ☐ Advertisment (list publicatiion): ________________
☐ 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: ________________

Relationship to patient: ______________________ SSN: ________________

Employer: ______________________________

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

Signature: ______________________ Date: ____________

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 for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Specimens sent for pathology or laboratory services are billed separately. Outstanding balances over 90 days may be referred to a collection agency, with associated patient expense. We accept payment in the form of cash, check, or credit card. A $50 return check fee will be charged.

Privacy Notice Acknowledgement
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.

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: ____________

Please present insurance cards and ID to Front Desk

Release of Protected Health Information

I allow the release of my health information to be shared with the following persons:

Name: ________________________________ Phone: ________________ Relationship:____________

Name: ________________________________ Phone: ________________ Relationship:____________

Name: ________________________________ Phone: ________________ Relationship:____________

Name: ________________________________ Phone: ________________ Relationship:____________

Signature: ___________________________ Date: ___________

My preferred phone is: (circle one) home or cell

If my preferred phone is cell, I accept text messages for appointment reminders and other notifications:
☐ yes ☐ no

It is okay to:
☐ Leave detailed messages regarding medical info such as Rx refills and follow-up after procedures
- or –
☐ Leave message with call back number only

We do not leave biopsy results on answering machines

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
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Strokes
- ❑ Other___________________

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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
- ❑ Skin Biospy
- ❑ Basal Cell Carcinoma Surgery
- ❑ Squamous Cell Carcinoma Surgery
- ❑ Melanoma Surgery
- ❑ 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

____
____
____
____
____

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

- ❑ NONE

____
____

Smoking Status: (please check all that apply)

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

Alcohol Status: (please check all that apply)

- ❑ 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)
- ❑ Other: _____________________________