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Patient Profile

New Pt () Update () Date _____

Last Name _____ First _____ MI _____

Social Security No. _____ Date of Birth _____ Age: _____

Home Address _____ City _____ State _____ Zip _____

Billing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Which number(s) for reminder calls: Home Cell Work If we reach a voicemail, may we leave a message: Yes No

If we reach someone other than you, may we leave a message: Name(s) _____

Primary Care Physician _____ Phone _____

Other Physicians You See _____

Reason for Visit _____ Referred to us by _____

Your Pharmacy Name & Phone Number _____

Employer _____ Occupation _____

Employer Address _____ Phone _____

Marital Status _____ Significant Other _____

Spouse's Employer _____ Occupation _____

Address _____ Phone _____

Emergency Contact (not in the same household) _____

Relationship _____ Home Phone _____ Work Phone _____

MEDICAL INSURANCE INFORMATION

If you are not the policyholder, we will need the policyholder's DOB and Social Security Number.

Primary Insurance Company: _____

Relationship to patient _____ Policyholder DOB _____

Policyholder's Social Security Number _____

Secondary Insurance Company: _____

Relationship to patient _____ Policyholder DOB _____

Policyholder's Social Security Number _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

MEDICAL HISTORY (Please check any which apply to you)

List any allergies including food or drug allergies: _____

Please list all medications you are currently taking or provide a list:

Have you ever taken Accutane / Tretinoin / Vit A / Retinol Products? Yes No Date / dosage _____

Do you use birth control pills? Yes No Are you currently pregnant? Yes No

Are you attempting pregnancy? Yes No Are you breast feeding? Yes No

Have you ever had herpes simplex or cold sores? Yes No Drug _____

Do you personally have any of the following:	Arthritis	Asthma	Bleeding Disorder/Problem
Clogged Arteries	Diabetes	High Blood Pressure	Thyroid Problems
Psoriasis	Eczema	Varicose Veins	Other Cancers
Seizures	Hepatitis B	Hepatitis C	HIV
Extremely Worried	Extremely Tired	Sleep Poorly	Unexplained Fevers
Systemic Lupus	Porphyria	Polycystic Ovary Syn	Unexplained Weight Loss

SURGICAL HISTORY (Please circle any which apply to you)

Appendix	Gall Bladder	Hysterectomy / Ovaries	Back	Neck	Arm / Leg	Breast
Skin Cancer	Nasal	Facial	Eye	Colon	Rectal	Bladder

Other _____

FAMILY HISTORY (List any important illnesses related to the following:)

Mother (if deceased please list age of death) _____

Father (if deceased please list age of death) _____

Brothers / Sisters (if deceased please list age of death) _____

SOCIAL HISTORY

Tobacco usage? Yes No Chew Smoke How much per week? _____

Alcohol usage? Yes No How many drinks per night? _____ Per week? _____

Are there children or parents you have to care for? Yes No

PHOTO CONSENT

I acknowledge the importance of documenting my care with before and after photos and give permission for **Summit Skin and Vein Care** to do so. I understand that my photographs may be used for insurance companies, reference, educational, training and/or marketing purposes without gratuity and that reasonable attempts to conceal my identity will be made. No listing of my name will be shown. Cropping of the picture will be performed to show primarily the affected areas.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

CANCELLATION POLICY FOR MEDICAL PATIENTS: We have now implemented a cancellation policy of a 24 hour notice of cancellation. If notice is not given within 24 hours, you will be billed a \$50.00 fee.

*For Insurance Patients Only
Affix Label*

Signature: _____

Date: _____