

Laser Surgery & Cosmetic Dermatology Centers, Inc  
32 Parking Plaza, Suite 200  
Ardmore, PA 19003

**THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY**  
**PATIENT INFORMATION FORM**

NAME \_\_\_\_\_  
(Last) (First) (Middle)

SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX: M F MARITAL STATUS: S M D W

HOME ADDRESS \_\_\_\_\_  
(Street) (Apt) (City) (State) (Zip)

HOME PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION: (IF OTHER THAN PATIENT)

NAME \_\_\_\_\_  
(Last) (First) (Middle)

RELATIONSHIP TO PATIENT \_\_\_\_\_

SS# OF INSURED \_\_\_\_\_ BIRTHDATE OF INSURED \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

HOME PHONE \_\_\_\_\_

I HAVE NO INSURANCE COVERAGE (PLEASE CHECK IF APPROPRIATE)

REFERRED BY  PHYSICIAN  FRIEND  OTHER \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE \_\_\_\_\_

I do hereby agree to pay the full and entire amount of the **consultation fee in addition to all bills for services rendered.**

\_\_\_\_\_  
(Sign Name) (Date)

As a member of a managed care group, I assume all responsibility for any services rendered that are not a part of my referral, whether or not covered or paid by my insurance, and **I will pay for those services at the time they are rendered.**

\_\_\_\_\_  
(Sign Name) (Date)

WORKER'S COMPENSATION AND OTHER PERSONAL INJURY TESTIMONY IN COURT

In order to provide the best possible service, care and availability to all of our patients, **it is our policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.**

\_\_\_\_\_  
(Sign Name) (Date)

Specialized Care

I understand that the Main Line Center for Laser Surgery is a tertiary referral practice. The physicians at our center will evaluate the specific problem for which you have been referred or have sought treatment. General dermatologic care and evaluation is the responsibility of the referring or primary physician. If you require a referral to a general dermatologist, please notify our office.

\_\_\_\_\_  
(Sign Name) (Date)

Reason for visit \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

**Have you ever been on Accutane?** YES NO **If yes please also inform the doctor verbally**

If you were on Accutane when \_\_\_\_\_

Do you have or have a history of **Cold Sores**? NO YES

Do you have or have a history of Scarring or Keloids? NO YES

Have you recently had a hormonal work-up for excessive hair growth? NO YES If yes when \_\_\_\_\_

Do you have regular menstrual cycles? NO YES

**Do/have you ever had permanent makeup/tattoos?** NO YES **If yes please also inform the doctor verbally**

If yes where? Eyebrows Eyeliner Lip liner Other \_\_\_\_\_

**Have you ever had Gold Therapy?** NO YES **If yes please also inform the doctor verbally**

Are you pregnant at this time? NO YES

**Do you faint when having blood drawn?** NO YES

**SOCIAL HISTORY: (CHECK ALL THAT APPLY)**

**Do you smoke?**  NO  YES - Frequency \_\_\_\_\_

**Do you use recreational drugs?**  NO  YES - Frequency \_\_\_\_\_

**Do you drink alcohol?**  NO  YES - Frequency \_\_\_\_\_

**Hobbies** \_\_\_\_\_

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**DRUG ALLERGIES: (LIST TYPE OF REACTION)**

ANESTHETICS \_\_\_\_\_

ASPIRIN \_\_\_\_\_

CODEINE \_\_\_\_\_

ERYTHROMYCIN \_\_\_\_\_

PENICILLIN \_\_\_\_\_

SULFA \_\_\_\_\_

TETRACYCLINE \_\_\_\_\_

OTHERS, please list \_\_\_\_\_

**NON-DRUG ALLERGIES:**  LATEX

OTHER (SPECIFY) \_\_\_\_\_

**PRE-MEDICATION REQUIRED PRIOR TO SURGERY**  NO  YES - List drug, dosage & duration \_\_\_\_\_

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**PRESENT/PAST MEDICAL HISTORY: (LIST CONDITIONS AND DATE)**

\_\_\_\_\_  
\_\_\_\_\_

**ARE YOU CURRENTLY TAKING MEDICATION?**

YES  NO **IF SO, PLEASE LIST:** \_\_\_\_\_

**SURGICAL HISTORY:** (LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)

\_\_\_\_\_  
\_\_\_\_\_

**REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY OF PATIENT (CHECK ALL THAT APPLY; USE C. IF CURRENT, USE P IF PAST)**

**CONSTITUTIONAL SYMPTOMS:**

- Fever  Hair loss
- Weight loss  Weight gain
- Chills  Tremor
- Nutritional Deficiencies
- Other, specify \_\_\_\_\_

**EYES:**

- Cataracts  Glaucoma
- Eyestrain  Blurring
- Inflammation
- Wear glasses
- Wear contacts
- Other, specify \_\_\_\_\_
- Date of last eye exam \_\_\_\_\_

**EARS, NOSE, MOUTH, THROAT:**

- Hearing difficulty
- Pain  Discharge
- Tinnitus (ringing in ears)
- Dizziness  Wear hearing aid
- Sinusitis  Postnasal drip
- Obstruction
- Gum Disease
- Chronic sores
- Herpes simplex infections
- Soreness  Redness
- Hoarseness
- Other, specify \_\_\_\_\_

**CARDIOVASCULAR:**

- Stroke  Palpitation
- Pacemaker  Rheumatic Fever
- Faintness  Pain
- High blood pressure
- Heart surgery
- Edema (swelling)
- Heart valve replacement
- Other, specify \_\_\_\_\_

**INFECTIOUS:**

- HIV Positive  AIDS Virus
- Hepatitis

**CANCER(S): (LIST TYPE, DATE, TREATMENT)**

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**RESPIRATORY:**

- Asthma  Chest pain
- Emphysema  Tuberculosis
- Lung disease
- Breathing disorder
- Bronchitis, chronic
- Sputum, with blood
- Cough, chronic
- Upper respiratory infection, chronic
- Other, specify \_\_\_\_\_

**GASTROINTESTINAL:**

- Ulcer  Pain
- Nausea  Constipation
- Diarrhea  Vomiting
- Appetite decrease
- Colon/intestinal disorder
- Other, specify \_\_\_\_\_

**GENITOURINARY:**

- Discharge  Urgency
- Sores  Incontinence
- Hesitancy
- Herpes simplex infections
- Other, specify \_\_\_\_\_

**MUSCULOSKELETAL:**

- Arthritis  Lupus
- Joint pain  Lupus of the skin
- Weakness  Joint swelling
- Joint replacement
- Cold sensitivity
- Other, specify \_\_\_\_\_

**INTEGUMENTARY:**

- Skin cancer(s)
- Acne  Hives
- Warts  Psoriasis
- Eczema  Cystic Acne
- Loss of Pigment
- Contact dermatitis
- Malignant Melanoma
- Scarring/keloids
- Herpes simplex (cold sores)

- Herpes Zoster (shingles)
- Other, specify \_\_\_\_\_

**NEUROLOGICAL:**

- Headaches  Convulsions
- Seizures  Migraine
- headaches
- Epilepsy  Fainting spells
- Memory loss
- Other, specify \_\_\_\_\_

**PSYCHIATRIC:**

- Stress  Depression
- Nightmares  Insomnia
- Anxiety  Suicidal Tendency
- Treatment of psychological disorder
- Other, specify \_\_\_\_\_

**ENDOCRINE:**

- Thyroid disorder
- Diabetes mellitus
- Excessive hair, face/body
- Other, specify \_\_\_\_\_

**HEMATOLOGIC/LYMPHATIC:**

- Anemia  Bruise easily
- Blood clots  Excessive bleeding
- Other, specify \_\_\_\_\_

**ALLERGIC/IMMUNOLOGIC:**

- Asthma  Frequent infections
- Allergies  Thyroiditis
- Vitiligo  Addison's Disease
- Pernicious anemia
- Hay Fever
- Other, specify \_\_\_\_\_

**MALES ONLY:**

- Urinary difficulties
- Prostatic problems

**FEMALES ONLY:**

- Chronic vaginal infections
- Currently pregnant
- Currently taking oral contraceptives
- Date of last menses \_\_\_\_\_

## PATIENT INFORMATION FORM

THE PRACTICE FINANCIAL POLICY WILL BE GIVEN TO PATIENTS AT THE TIME OF REGISTRATION.  
ALL PATIENTS MUST SIGN THIS FORM.

### OUR PRACTICE FINANCIAL POLICY

The physicians and staff at our office are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we accept Visa, MasterCard, American Express, Discover, Cash and Personal checks.

### YOUR INSURANCE

We have made prior arrangements with some insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The copayment will be collected when you arrive for your appointment. In the event your health plan determines a service to be not covered, you will be responsible for the complete charge. In that event, you will receive a statement at the time of service and payment is due at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare a statement for you to attach to your insurance claim form for processing of payment. In this case, the insurance carrier will send the payment directly to you. Therefore, charges for your care and treatment are due at the time service is rendered.

Any balance due is your responsibility and is due upon receipt of a statement from our office.

### MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

### MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, we ask that you please call us as early as possible if you know you will need to reschedule your appointment.

*I have read and understand the financial policy of the practice and I agree to be bound by its items. I also understand and agree that such terms may be amended from time-to-time by the practice.*

\_\_\_\_\_  
(Signature of the Patient or Responsible Party)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Please Print the Name of the Patient)