



PLEASE PRINT LEGIBLY

ALL (*) ITEMS ARE REQUIRED

PATIENT INFORMATION

Prefix: _____ ***Last Name:** _____ ***First Name:** _____

Middle Name: _____ Suffix: _____ Nickname: _____

Marital Status: _____ ***Social Security Number:** _____

***Date of Birth:** _____ City of Birth: _____ ***Birth Sex:** M / F

Language Spoken: _____ Ethnic Group: _____ Race: _____

***Street Address:** _____ ***Address Line 2:** _____

***City:** _____ ***State:** _____ ***Zip:** _____ Country: _____

Employer's Name: _____ Occupation: _____

Employment Status: FULL-TIME PART-TIME RETIRED DISABLED STUDENT UNEMPLOYED

***Preferred Phone Number (Circle One):** HOME WORK MOBILE

***Home #:** _____ Work #: _____ ***Mobile #:** _____

***Is it OK to leave a detailed message:** YES NO

Email: _____ Alternate Email: _____

***Would you like to opt into email notification:** YES NO

***Emergency Contact Name:** _____ ***Phone Number:** _____

Spouse Full Name: _____ Phone Number: _____

Caretaker Full Name: _____ Phone Number: _____

GUARDIAN INFORMATION (Under 18 ONLY)

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Guardian's Name: _____ Phone Number: _____



INSURANCE INFORMATION

Plan Name: _____ *Policy Type: _____

*Policy Number: _____ Group Number: _____

Name on Insurance Card Last Name: _____ First Name: _____

Policy Holder Relationship: SELF SPOUSE CHILD OTHER

Does your insurance have a preferred Laboratory? NO YES If Yes Laboratory Name: _____

RESPONSIBLE PARTY

*Relationship to Patient (Circle One): SELF SPOUSE CHILD OTHER

*Last Name: _____ First Name: _____ Middle Initial: _____

Prefix: _____ *Date of Birth: _____ Social Security Number: _____

*Street Address: _____ Address Line 2: _____

*City: _____ *State: _____ *Zip: _____ *Country: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____ Alternate Email: _____

RELEASE OF PERSONAL RECORDS

I, _____ hereby give my permission to Lux Dermatology to release any information pertaining to me to the following:

Full Name: _____ Relationship to Pt: _____

Home Number: _____ Mobile Number: _____

PHARMACY INFORMATION

*Pharmacy Name: _____ * Address: _____

*City: _____ * State: _____ * Zip: _____ * Phone: _____



PAST MEDICAL CONDITIONS (Circle All that Apply)

ARTHRITIS CHRONIC OBSTRUCTIVE LUNG DISEASE DEPRESSIVE DISORDER
DIABETES MELLITUS END-STAGE RENAL DISEASE HISTORY OF HYPERTENSION
H.I.V. HYPERCHOLESTEROLEMIA LEUKEMIA
MALIGNANT LYMPHOMA MALIGNANT TUMOR OF THE COLON HEARING LOSS
LAST MENSTRUAL DATE: _____

PAST SURGERIES (Circle All that Apply)

HISTORY OF COLECTOMY KIDNEY TRANSPLANT EXCISION OF MELANOMA HEART TRANSPLANT
JOINT REPLACEMENT LIVER TRANSPLANT MECHANICAL HEART VALVE REPLACEMENT
OTHER: _____

SKIN CONDITIONS (Circle All that Apply)

ACNE ACTINIC KERATOSIS BASAL CELL CARCINOMA OF SKIN
DYSPLASTIC NEVUS OF SKIN ECZEMA FAMILY HISTORY OF MELANOMA
HISTORY OF ASTHMA MALIGNANT MELANOMA PSORIASIS
SQUAMOUS CELL CARCINOMA SUNBURN OF SECOND-DEGREE SUN PROTECTION SPF: _____

ALLERGIES (Please list all allergies & types of reactions)



MIPS Patient Intake Form

Name: _____ DOB: _____ Email: _____

Primary Care Physician: _____ Referring Physician: _____

Melanoma:

Have you ever been diagnosed with Melanoma? Yes No

If YES, did you ever have a chest X-ray, CT, Ultrasound, MRI, or PET? Yes No

Alcohol Use:

How often do you have an alcoholic beverage?

Never Less than one drink per day 1-2 drinks per day 3 or more drinks per day

Tobacco Use: (Please choose the option that best describes tobacco use)

Never Current everyday smoker Current some day smoker Former Smoker

Current Smokers: 1-3 cigarettes per day Up to 1 pack per day
 1-2 packs per day 2 or more packs per day

Current Medications: (Include Name, Dosage, Frequency, & How it is Taken)

Children 12 Years of Age Vaccine Status:

HPV: Yes No. TDAP: Yes No. Meningococcal: Yes No

65 years & Over: Do you have the following:

Power of Attorney (Surrogate Decision Maker) Living Will None
Name/Relationship: _____ (Advance Care Plan)



COSMETIC QUESTIONNAIRE

Name _____ Date _____

Which Of the following overall aesthetic conditions would you like to learn more about?

- | | | |
|---|--|---|
| <input type="checkbox"/> Skincare Advice | <input type="checkbox"/> Facial Wrinkles (Botox) | <input type="checkbox"/> Neck Wrinkles |
| <input type="checkbox"/> Skincare Products | <input type="checkbox"/> Facial Fine Lines (Fillers) | <input type="checkbox"/> Drooping Brows |
| <input type="checkbox"/> Blotchy Skin | <input type="checkbox"/> Thin Lips | <input type="checkbox"/> Chest Wrinkles |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Facial Hair Reduction | <input type="checkbox"/> Abdominal Contouring |
| <input type="checkbox"/> Facial Veins | <input type="checkbox"/> Body Hair Reduction | <input type="checkbox"/> Inner/Outer Leg Contouring |
| <input type="checkbox"/> Facial Redness | <input type="checkbox"/> Drooping Eyelids | <input type="checkbox"/> Facial Contouring |
| <input type="checkbox"/> Facial Fullness/Drooping | <input type="checkbox"/> Mole Removal | <input type="checkbox"/> Arm Contouring |
| <input type="checkbox"/> Acne Scarring | <input type="checkbox"/> Leg Veins | <input type="checkbox"/> Microneedling |
| <input type="checkbox"/> Other: _____ | | |

For the following statements, please circle the number that best reflects your opinion, with 1 as agreeing the least and 5 as agreeing the most.

1. I am unhappy with my appearance and would like to discuss non surgical treatment options but I don't know where to start.

1 2 3 4 5

2. If effective, non-surgical options were available to successfully correct my lines and wrinkles, I would be interested.

1 2 3 4 5

3. I would like more information on the cosmetic services offered at Lux Dermatology.

1 2 3 4 5

Are you interested in meeting with our cosmetic team to create a personalized treatment plan designed to meet your specific cosmetic needs?

- Yes No

Do you give us permission to send you information on products and services (including special offers)?

- Yes No

Signature _____