LUX DERMATOLOGY

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: _____

LUX DERMATOLOGY

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:** _____

LUX DERMATOLOGY

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)

_____

_____

_____

_____

_____

573 W. Putnam Avenue, Porterville, CA 93257 www.luxdermatologists.com
Phone: (559) 781-1812 Fax: (559) 781-3852

LUX DERMATOLOGY

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)

LUX DERMATOLOGY
MEDICAL SURGICAL COSMETIC

COSMETIC QUESTIONNAIRE

Name _____ **Date** _____

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

- ☐ Skincare Advice
- ☐ Skincare Products
- ☐ Blotchy Skin
- ☐ Chemical Peels
- ☐ Facial Veins
- ☐ Facial Redness
- ☐ Facial Fullness/Drooping
- ☐ Acne Scaring
- ☐ Facial Wrinkles (Botox)
- ☐ Facial Fine Lines (Fillers)
- ☐ Thin Lips
- ☐ Facial Hair Reduction
- ☐ Body Hair Reduction
- ☐ Drooping Eyelids
- ☐ Mole Removal
- ☐ Leg Veins
- ☐ Neck Wrinkles
- ☐ Drooping Brows
- ☐ Chest Wrinkles
- ☐ Abdominal Contouring
- ☐ Inner/Outer Leg Contouring
- ☐ Facial Contouring
- ☐ Arm Contouring
- ☐ Microneedling
- ☐ 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 your 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 premission to send you information on products and services (including special offers)?

- ☐ Yes
- ☐ No

Signature _____