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:** ______________

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)

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 ______________________