Medical History

First Name ______________MI_________Last__________________________ Date of Birth____________
Sex_________ Marital Status____________ Social Security Number______________________
Address ____________________________ City ______________________State___Zip___________
Home Phone _________________________ Cell Phone_________________________
Work Phone____________________ Which number is best to contact you? (Circle One) HM Cell WK
Email address______________________________
Referred by ______________________________________ How did you hear about us____
Emergency Contact: (name, phone, town)________________________________Family Doctor:____________________________________
Occupation? (If retired what did you do?)____
Employer Name and Address:____
(# and Street or Route) City State (Zip)
May we leave Clinic or Medical messages on your answering machine? ○no ○ yes

If you want re*be to file your insurance: or let us copy your insurance card

Insurance Information

Billing Name (If it is not you)_____________________________________Relationship to Patient___________________________
Address (if not the same)____
(# and Street or Route) City State (Zip)
Is this work related? □Yes □ No

Primary Insurance ________________________________
Address ____________________________________
City & State____________________________________
Name of Policy Holder___________________________
Policy Holder's DOB______________________________
Policy Holder's SS#_______________________________
Policy Holder's Employer_________________________
Policy ID Number ________________________________
Group Number____________________________________

Secondary Insurance ____________________________________
Address____
City & State____
Name of Policy Holder___________________________________
Policy Holder's DOB______________________________________
Policy Holder's SS#_______________________________________
Policy Holder's Employer_________________________________
Policy ID Number____
Group Number____

Please check with your insurance company to see if they require prior authorization for your procedures.

ALLERGIES	MEDICATIONS	OPERATIONS	ILLNESS

Why did you come to see us?:

- ☐ Veins
- ☐ Sun spots
- ☐ Lipo Dissolve
- ☐ Wrinkles
- ☐ Facial Rejuvenation
- ☐ Hair removal
- ☐ Enlarged blood vessels
- ☐ Acne
- ☐ Other
- ☐ Flushing of the skin
- ☐ Botox
- ☐ Large pores
- ☐ Fillers
- ☐ Moles
- ☐ Warts
- ☐ Skin Products

How long have you been concerned about this?______________**Have you ever been treated for this before?** ○**no** ○ **yes**
What are your chances of being pregnant now? none/low/possibly/high/100% How far along?__________________________
How many children do you have? _________

DO YOU… **?**

Spray/Cream Tan ○**no** ○ **yes**
Smoke ○**no** ○**yes**
Drink ○**no** ○**yes**
- ❑ Rare
- ❑ Social
- ❑ Probably more than the doctor

WEAR…

Glasses or contacts ○**no** ○**yes**
Hearing Aids ○**no** ○**yes**
Truss/Supports ○**no** ○**yes**

HAVE…

High Blood pressure ○**no** ○ **yes**
Heart Murmur ○**no** ○ **yes**
Asthma/Emphysema ○**no** ○ **yes**
TB/HIV/Cancer ○**no** ○ **yes**
Implants ○**no** ○ **yes**
- ❑ orthopedic
- ❑ heart valve
- ❑ pacemaker
- ❑ ports
- ❑ pumps
- ❑ breast
- ❑ dental
- ❑ chin
- ❑ penile

Arthritis ○**no** ○ **yes**
Diabetes ○**no** ○ **yes**
Thyroid problems ○**no** ○ **yes**
Liver disease ○**no** ○ **yes**
Bleeding tendencies ○**no** ○ **yes**
Clotting tendencies ○**no** ○ **yes**
Healing Problems ○**no** ○ **yes**
Regular Health Exams ○**no** ○ **yes**

(Please continue on the back)

HAVE YOU EVER HAD A... ?

Reaction to latex	○**no** ○ **yes**
Reaction to anesthesia	○**no** ○ **yes**
Fever Blister	○**no** ○ **yes**
Kidney stone	○**no** ○ **yes**
Heart Attack	○**no** ○ **yes**
Seizure or Stroke	○**no** ○ **yes**
Migraine Headache	○**no** ○ **yes**
Rhythm Problem	○**no** ○ **yes**
□ Irregular □ too fast □ too slow	
Serious injury	○**no** ○ **yes**

FAMILY HISTORY

Varicose Veins?	○**no** ○ **yes**
Problems with anesthesia	○**no** ○ **yes**
Skin Cancers run in your family?	○**no** ○ **yes**
Bleeding or clotting Problems in your family?	○**no** ○ **yes**

VEINS **(If you are *NOT* HERE FOR VEINS Skip This**

Problem with ○**right leg** ○ **left leg** ○**both legs**

VEINS HAVE YOU EVER... ?

Missed work	○**no** ○ **yes**
Asked for treatment	○**no** ○ **yes**
Left work early	○**no** ○ **yes**
Avoided any activities	○**no** ○ **yes**

HAD ANY...

Burning	○**no** ○ **yes**
Itching	○**no** ○ **yes**
Tingling	○**no** ○ **yes**
Heaviness	○**no** ○ **yes**
Discomfort	○**no** ○ **yes**
Tightness	○**no** ○ **yes**
Aching, Pain	○**no** ○ **yes**
Ankle Swelling	○**no** ○ **yes**
Fatigue	○**no** ○ **yes**
Restless Legs	○**no** ○ **yes**
Discoloration	○**no** ○ **yes**
Throbbing	○**no** ○ **yes**
Ulcers	○**no** ○ **yes**
Skin Changes	○**no** ○ **yes**
Cramps at night	○**no** ○ **yes**
Vein problems pregnant?	○**no** ○ **yes**
Pain on your period	○**no** ○ **yes**

VEIN TREATMENTS ○**no** ○ **yes**

- ❑ Compression stockings
- ❑ Sclerotherapy
- ❑ Vein Stripping
- ❑ Laser or VNUS
- ❑ Ultrasounds
- ❑ Vein Xray
- ❑ Other

IF YOU ARE CURRENTLY RECEIVING MEDICARE BENEFITS, PLEASE COMPLETE THE MEDICARE BENEFICIARY INFORMATION**

Medicare beneficiaries age 65 or over:

1. Is this injury or illness covered by workers compensation? ○**no** ○ **yes**
   If yes, list employer name and address____
2. Are these services a result of an accident? ○**no** ○ **yes**
   If so, what type of accident and who is the responsible party?____
   Name and policy number of the auto, non-auto liability or no-fault insurer?____________________________
3. Are you covered by the Federal Black Lung Program? ○**no** ○ **yes**
4. Has the Department of Veterans Affairs (DVA) agreed to pay for services at this facility? ○**no** ○ **yes**
5. Are these services covered by any other Public Health Service (i.e. Indian Health Services)? ○**no** ○ **yes**
6. Are the services to be paid for by a government program or research grant? ○**no** ○ **yes**
7. Are you entitled to Medicare because of(Check one or multiple: Age_______ Disability________ End Stage Renal Disease______
8. Is the patient 65 years of age or older? ○**no** ○ **yes**
9. Is the patient currently employed by an employer of 20 or more employees? ○**no** ○ **yes**
   If yes, are you covered under your employer's group health plan? ○**no** ○ **yes**
   If no, what was your retirement date?____
10. Is the patient's spouse currently employed by an employer of 20 or more employees? ○**no** ○ **yes**
    If yes, are you covered under your spouse's employer's group health plan? ○**no** ○ **yes**
    If no, what was your spouse's retirement date?____

AUTHORIZATION FOR TREATMENT: Realizing that I require medial care, I do hereby voluntarily consent to such medical care encompassing such diagnostic and medial treatment by My Skin Clinics, and students in educational programs affiliated with My Skin Clinics. I consent to testing for HIV (AIDS) and or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.
RELEASE OF INFORMATION: I hereby authorize My Skin Clinics to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to the third party payers and their reviewing contractors to comply with preadmissions review and continued stay requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care. I am aware that re*be is a medical clinic and is bound by the same health care privacy act as any other medical clinic or facility. I am aware that at any time I can request and will receive a copy of the **re*be Privacy Policy** for health care information from the staff at re*be.
ASSIGNMENT OF BENEFITS: Authorization is hereby granted for the direct payment to My Skin Clinics for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

______________________________________ ______________________________________
Patient Signature (if Under 18) Patient Representative

______________________________________ ______________________________________
Date Relationship to Patient