Medical History

re*be®
the science of better skin

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 _____	Secondary Insurance _____
Address _____	Address_____
City & State_____	City & State_____
Name of Policy Holder_____	Name of Policy Holder_____
Policy Holder's DOB_____	Policy Holder's DOB_____
Policy Holder's SS#__ _____	Policy Holder's SS#___ _____
Policy Holder's Employer_____	Policy Holder's Employer_____
Policy ID Number _____	Policy ID Number_____
Group 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	☐ Facial Rejuvenation	☐ Other	☐ Fillers
☐ Sun spots	☐ Hemorrhoids	☐ Flushing of the skin	☐ Moles
☐ Lipo Dissolve	☐ Enlarged blood vessels	☐ Botox	☐ Warts
☐ Wrinkles	☐ Acne	☐ Large pores	☐ Skin

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... ?

Sunscreen ○no ○ yes
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/AIDS ○no ○ yes
Implants ○no ○ yes
- ❑ Orthopedic ○ dental
- ❑ heart valve ○ chin
- ❑ pacemaker ○ penile
- ❑ ports
- ❑ pumps
- ❑ breast

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

FAMILY HISTORY

Varicose Veins?	○no ○ yes	**Skin Cancers/ Melanoma run in your family?**	○no ○ yes
Problems with anesthesia	○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	**Ankle Swelling**	○no ○ yes	**VEIN TREATMENTS**	○no ○ yes
Asked for treatment	○no ○ yes	**Fatigue**	○no ○ yes	❑ Sclerotherapy	
Left work early	○no ○ yes	**Restless Legs**	○no ○ yes	❑ Vein Stripping	
Avoided any activities	○no ○ yes	**Discoloration**	○no ○ yes	❑ Laser or VNUS	
HAD ANY...		**Throbbing**	○no ○ yes	❑ Ultrasounds	
Burning	○no ○ yes	**Ulcers**	○no ○ yes	❑ Vein Xray	
Itching	○no ○ yes	**Skin Changes**	○no ○ yes	❑ Other	
Tingling	○no ○ yes	**Cramps at night**	○no ○ yes	❑ Compression stockings	
Heaviness	○no ○ yes	**Vein problems pregnant?**	○no ○ yes	Circle One:	
Discomfort	○no ○ yes	**Pain on your period**	○no ○ yes	Knee High/ Thigh High/ Panty	
Tightness	○no ○ yes	**Pulminary Embolism**	○no ○ yes		
Aching, Pain	○no ○ yes	**Blood Clot**	○no ○ yes		
		Prescribed Coumadin or heparin? ____			

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