DELRAY DERMATOLOGY
+ COSMETIC CENTER

Patient Personal Information

Full Name: _____

Date of birth:_____ **Age:**_____ **Social Security Number:** _____

Cell phone number: (☐ preferred) (_____)_____-_____

Home phone Number: (☐ preferred) (_____)_____-_____

Email address: _____

Local Address: _____

City: _____ **State:** _____**Zip code:** _____

Secondary out of state address: _____

City: _____ **State:** _____**Zip code:** _____

Primary Care Doctor: _____**Phone Number:**_____

Referring Doctor: _____**Phone Number:**_____

Emergency Contact: _____ **Relationship:** _____

Phone Number: (_____)_____-_____

If patient is a minor, custodial parent: _____

Mother: _____ **Phone number: (**_____)_____-_____

Father: _____ **Phone number: (**_____)_____-_____

Insurance Information

Primary Insurance Company: _____ **Primary Insured's Name:** _____

Relationship: _____ **Date of Birth of insured:** _____

Secondary Insurance Company: _____ **Primary Insured's Name:** _____

Relationship: _____ **Date of Birth of insured:** _____

I would like to receive appointment reminders by: ☐ **Text** ☐ **Email**

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Patient Name: _____

Occupation: _____ **Employer:** _____

Reason for today's visit: _____

I authorize Delray Dermatology + Cosmetic Center to leave a voicemail with medical results/info:

☐ **Yes** ☐ **No**

How did you hear about us:

☐ **I was a previous patient of Dr. Lewis**

☐ **My doctor**

☐ **Friend** _____

☐ **Atlantic Ave Magazine**

☐ **Delray Newspaper**

☐ **Google**

☐ **Facebook**

☐ **Saw your sign**

☐ **Insurance directory**

Please place a check next to products/procedure you are interested in:

☐ **Complimentary cosmetic consultation**

☐ **Complementary skin care regimen recommendations**

☐ **Aesthetic services (Oxygeneo superfacial, microneedling, PRP)**

☐ **Neuromodulators (Botox, Dysport)**

☐ **Fillers (Juvederm, Restylane, Radiesse)**

☐ **Laser treatments (for redness, brown spots)**

☐ **Laser treatments (for wrinkles)**

☐ **Latisse**

☐ **Kybella**

Optional Cosmetic Concerns:

☐ **Acne scars**

☐ **Broken blood vessels on the face (telangiectasias)**

☐ **Brown Spots**

☐ **Loose Skin**

☐ **Wrinkles**

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Authorization to discuss/release medical information

I, _____, allow the release of my health information to

the following people or and/or organization(s):

Name(s) & Relationship(s):

_____ _____

_____ _____

_____ _____

_____ _____ _____

Patient Name (PRINT) **Signature** **Date**

_____

Relationship to patient (if other than patient)

DELRAY DERMATOLOGY
+ COSMETIC CENTER

Patient Name: _____

Review of Systems

	YES	NO
Allergy to Latex	☐	☐
Allergy to adhesive	☐	☐
Allergy to Lidocaine	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Problems with bleeding	☐	☐
Problems with healing	☐	☐
Problems with scarring (hypertrophic or keloid)	☐	☐
Rash	☐	☐
Growing skin lesions	☐	☐
MRSA	☐	☐
Artificial heart valve	☐	☐
Artificial joints within the past 2 years	☐	☐
Blood thinners	☐	☐
Defibrillator	☐	☐
Pacemaker	☐	☐
Require premedication prior to procedures	☐	☐
Rapid heart beat with epinephrine	☐	☐
Pregnancy or planning pregnancy	☐	☐
Immunosuppression	☐	☐
Hay fever	☐	☐
Fever or chills	☐	☐
Night sweats	☐	☐
Unintentional weight loss	☐	☐
Thyroid problems	☐	☐
Blurry vision	☐	☐
Joint aches	☐	☐
Headaches	☐	☐
Anxiety	☐	☐
Depression	☐	☐