



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

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

Mailer

Google

Facebook

Fashion Week

Saw your sign

Insurance directory

Coastal Star

Charity Sponsorship

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

Complimentary cosmetic consultation

Oxygeneo Facial

Complementary skin care regimen recommendations

NovaThreads

Aesthetic services (Microneedling, PRP)

Kybella

Neuromodulators (Botox, Dysport)

Fillers (Juvederm, Restylane, Radiesse)

Laser treatments (for redness, brown spots)

Laser treatments (for wrinkles)

Latisse (To grow eyelashes)

Optional Cosmetic Concerns:

Acne scars

Loose Skin

"11 Lines"

Crows Feet

Wrinkles

Brown Spots

Forehead Lines

Marionette Lines

Double Chin

Smile Lines/Parantheses Lines

Loss of Volume in the Lips

Broken blood vessels on the face (telangiectasias)



DELRAY DERMATOLOGY
+ COSMETIC CENTER

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)



Patient Name: _____

Review of Systems

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