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 ☐ 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/Parentheses Lines

☐ Loss of Volume in the Lips ☐ Broken blood vessels on the face (telangiectasias)

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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)

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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	☐	☐