

Main Line Center for Laser Surgery
32 Parking Plaza, Suite 200
Ardmore, PA 19003

THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY
PATIENT INFORMATION FORM

NAME _____
(Last) (First) (Middle)

SS# _____ BIRTHDATE _____ SEX: M F MARITAL STATUS: S M D W

HOME ADDRESS _____
(Street) (Apt) (City) (State) (Zip)

HOME PHONE _____ E-MAIL _____

WORK PHONE _____ CELL PHONE _____

OCCUPATION _____

EMPLOYER NAME _____

RESPONSIBLE PARTY INFORMATION: (IF OTHER THAN PATIENT)

NAME _____
(Last) (First) (Middle)

RELATIONSHIP TO PATIENT _____

SS# OF INSURED _____ BIRTHDATE OF INSURED _____

HOME ADDRESS _____
(Street) (City) (State) (Zip Code)

HOME PHONE _____

I HAVE NO INSURANCE COVERAGE (PLEASE CHECK IF APPROPRIATE)

REFERRED BY PHYSICIAN FRIEND INTERNET OTHER PHONE # _____

ADDRESS _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

ADDRESS _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE _____

I do hereby agree to pay the full and entire amount of the **consultation fee in addition to all bills for services rendered.**

(Sign Name) (Date)

As a member of a managed care group, I assume all responsibility for any services rendered that are not a part of my referral, whether or not covered or paid by my insurance, and **I will pay for those services at the time they are rendered.**

(Sign Name) (Date)

WORKER'S COMPENSATION AND OTHER PERSONAL INJURY TESTIMONY IN COURT

In order to provide the best possible service, care and availability to all of our patients, **it is our policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.**

(Sign Name) (Date)

Specialized Care

I understand that the Main Line Center for Laser Surgery is a tertiary referral practice. The physicians at our center will evaluate the specific problem for which you have been referred or have sought treatment. General dermatologic care and evaluation is the responsibility of the referring or primary physician. If you require a referral to a general dermatologist, please notify our office.

(Sign Name) (Date)

Reason for visit _____

How long have you had this problem? _____

Name of General Dermatologist _____

Do you see a Skin Care specialist or Esthetician? _____

Have you recently had any other treatments such as Botox or fillers? _____

Have you ever been on Accutane? YES NO **If yes please also inform the doctor verbally**

If you were on Accutane when _____

Do you have or have a history of Cold Sores? NO YES

Do you have or have a history of Scarring or Keloids? NO YES

Have you recently had a hormonal work-up for excessive hair growth? NO YES If yes when _____

Do you have regular menstrual cycles? NO YES

Do/have you ever had permanent makeup/tattoos? NO YES **If yes please also inform the doctor verbally**

If yes where? Eyebrows Eyeliner Lip liner Other _____

Have you ever had Gold Therapy? NO YES **If yes please also inform the doctor verbally**

Are you pregnant at this time? NO YES

Do you faint when having blood drawn? NO YES

SOCIAL HISTORY: (CHECK ALL THAT APPLY)

Do you smoke? NO YES - Frequency _____

Do you use recreational drugs? NO YES - Frequency _____

Do you drink alcohol? NO YES - Frequency _____

DRUG ALLERGIES: (LIST TYPE OF REACTION)

- | | |
|---|--|
| <input type="checkbox"/> ANESTHETICS _____ | <input type="checkbox"/> ASPIRIN _____ |
| <input type="checkbox"/> CODEINE _____ | <input type="checkbox"/> ERYTHROMYCIN _____ |
| <input type="checkbox"/> PENICILLIN _____ | <input type="checkbox"/> SULFA _____ |
| <input type="checkbox"/> TETRACYCLINE _____ | <input type="checkbox"/> OTHERS, please list _____ |

NON-DRUG ALLERGIES: LATEX
 OTHER (SPECIFY) _____

PRE-MEDICATION REQUIRED PRIOR TO SURGERY NO YES - List drug, dosage & duration _____

PRESENT/PAST MEDICAL HISTORY: (LIST CONDITIONS AND DATE)

ARE YOU CURRENTLY TAKING MEDICATION?

YES NO **IF SO, PLEASE LIST:** _____

SURGICAL HISTORY: (LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)

