Laser Light
SKIN CLINIC

MEDICAL HISTORY FORM

(please print clearly)

Date_____/_____/_____

First_____ MI____ Last_____

Home Address_____

City_____ State_____ Zip Code_____

Services Interested:_____

May we contact you here?

Home Phone (_____)_____ *yes no*

Cell Phone (_____)_____ *yes no*

E-mail address _____ *yes no*

Date of Birth _____/_____/_____Age_____

Employer _____Occupation_____

Primary Care Physician_____ Pharmacy Phone_____

Emergency Contact _____Phone (_____) _____

How did you hear about us, or whom may we thank for referring you to Laser Light Skin Clinic?_____

Circle each of the following that you are currently taking or have taken in the past 30 days:

Aspirin Accutane Ibuprofen Aleve Plavix Vitamin E

List other current medications:_____

_____

List any known drug allergies:_____

Have you ever had an adverse reaction to anesthetic (e.g.,dentist)? *yes no*

Circle each skincare product that you are currently using or have used in the past 30 days:

Retin A Tazorac Avage Prevage Retinol C+E Ferulic

List any other skin care product: _____

Do you use or have you ever used tobacco products? *yes no* If yes, last date of use_____

Women: Are you pregnant? *yes no*

Are you nursing? *yes no* Date of last menstrual period?_____

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Do you have, or have you ever had, any of the following medical conditions?

	Circle one		Explain
Heart condition	Yes	No	_____
High Blood Pressure	Yes	No	_____
Circulation problems	Yes	No	_____
Diabetes	Yes	No	_____
Fainting/dizziness	Yes	No	_____
Stroke	Yes	No	_____
Cancer	Yes	No	_____
Herpes (cold sores)	Yes	No	_____
Asthma/COPD	Yes	No	_____
Bleeding disorders	Yes	No	_____
Menopause symptoms	Yes	No	_____
Visual problems	Yes	No	_____
Chemotherapy/Radiation	Yes	No	_____
Neurological disorder	Yes	No	_____
Neuromuscular disorders	Yes	No	_____
Autoimmune disorder	Yes	No	_____
Chronic infections	Yes	No	_____
Kidney problems	Yes	No	_____
Stomach ulcer/gastritis	Yes	No	_____
Chronic Headaches	Yes	No	_____
Gallbladder problems	Yes	No	_____
Other	Yes	No	_____
Pacemaker	Yes	No	_____
Intratrochlear Implant	Yes	No	_____
Spinal Stimulator	Yes	No	_____

Please list major surgeries, and approximate date_____

_____

Have you had any of the following treatments, procedures or surgeries?

	Circle one		Explanation
Botox	Yes	No	_____
Dermal Fillers	Yes	No	_____
Chemical Peels	Yes	No	_____
Laser Treatments	Yes	No	_____
Liposuction	Yes	No	_____
Face or Neck lift	Yes	No	_____
Blepharoplasty (eye lift)	Yes	No	_____
Breast augmentation	Yes	No	_____
Abdominoplasty (tummy tuck)	Yes	No	_____
Other cosmetic procedures	Yes	No	_____

Recommendations:

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REFUND POLICY

I _____ understand that Laser Light Skin Clinic offers no refunds on any procedure. If you choose not to have a procedure, you may have a credit at the clinic for any service of equal value.

We thank you and appreciate you for your business!

Sincerely,

Laser Light Skin Clinic

Signature _____

Date _____

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. We expect that Medicare will not pay for the item(s) or service(s) that are described below.Medicare does not pay for all of your health care costs. Medicare only pays for covered itemsand services when Medicare rules are met. The fact that Medicare may not pay for a particularitem or service does not mean that you should not receive it. There may be a good reason yourdoctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not youwant to receive these items or services, knowing that you might have to pay for them yourself.Before you make a decision about your options, you should **read this entire notice carefully.**

• Ask us to explain, if you don't understand why Medicare probably won't pay.

• Ask us how much these items or services will cost you (**Estimated Cost: $**_____),in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision**.**

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit aclaim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on thisform will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare**.**

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