Dedicated to Health Medical Group, INC
3235 E. Colorado Blvd., STE 101
Pasadena, CA 91107
626-799-0557 (B) * (626) 799-2732 (F)

---------- NEW PATIENT INTAKE INFORMATION ----------

Your Name (Last, First) _____, _____ Date_____

Social Security Number: _____ Date of Birth: _____ Age: _____ Gender (please circle): M F

Address: _____ Apartment # _____ or N/A

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home: _____ Work: _____

Best number to leave any confidential information regarding your treatment and messages: (please circle) Mobile Home Work

E-mail address: _____ How did you hear about us? _____

Name and number of the person(s) we may speak to regarding your health (spouse, child, etc.): _____

Primary Care Physician Name: _____ Phone Number: _____

Emergency Contact Name: _____ Number: _____ Relationship: _____

Pharmacy Name: _____ Pharmacy Number: _____

---------- PAST MEDICAL HISTORY ----------

Heart Disease (Heart Attack, etc.)?	NO	YES	(If YES, explain) _____
Neurological Disease (Seizures, Headaches)?	NO	YES	(If YES, explain) _____
Lung Disease (COPD, Asthma, etc.)?	NO	YES	(If YES, explain) _____
Liver or Kidney Disease (Hepatitis, etc.)?	NO	YES	(If YES, explain) _____
Cancer (Leukemia, Lymphoma)?	NO	YES	(If YES, explain) _____
Digestive Problems (IBS, etc.)?	NO	YES	(If YES, explain) _____
Do you have Hypertension ?	NO	YES	(If YES, explain) _____
Trauma (serious car accidents, injuries, etc.)?	NO	YES	(If YES, explain) _____
Do you have Diabetes or “pre-diabetes”?	NO	YES	(If YES, explain) _____
Immunosuppression (HIV, AIDS, etc.)?	NO	YES	(If YES, explain) _____
Endocrine Disorder (Thyroid Disease, etc.)?	NO	YES	(If YES, explain) _____
Have you ever had Surgery?	NO	YES	(If YES, explain) _____
Do you have any OTHER medical problems?	NO	YES	(If YES, explain) _____

---------- SOCIAL HISTORY ----------

Marital Status (please circle): Single Married Widowed Divorced

Occupation: _____ Hobbies: _____

Do you now, or did you ever, drink alcohol? NO YES (if YES, explain) _____

Do you now, or did you ever, smoke? NO YES (if YES, explain) _____

Do you now, or did you ever, use IV drugs? NO YES (if YES, explain) _____

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---------- PAST DERMATOLOGY HISTORY ----------

Family History of Skin Cancer?	NO	YES	(If YES, explain) _____
Personal History of Skin Cancer?	NO	YES	(If YES, explain) _____
Did you have bad Sunburns as a child?	NO	YES	(If YES, explain) _____
Have you ever had a Mole removed?	NO	YES	(If YES, explain) _____
Do you have Acne, Acne Scarring?	NO	YES	(If YES, explain) _____
Do you have Keloids or Scars?	NO	YES	(If YES, explain) _____
Do you have Psoriasis?	NO	YES	(If YES, explain) _____
Skin Allergies, rashes or itching?	NO	YES	(If YES, explain) _____
Have you ever used a neurotoxin (Botox®)?	NO	YES	(If YES, explain) _____
Have you ever used filler?	NO	YES	(If YES, explain) _____
Have you ever had a chemical peel?	NO	YES	(If YES, explain) _____
Have you ever had a laser procedure	NO	YES	(If YES, explain) _____
Any OTHER Skin problem or treatment?	NO	YES	(If YES, explain) _____

---------- CURRENT DERMATOLOGY STATUS ----------

Are you ALLERGIC to any medications? ❒ NO ❒ YES If YES, please list: _____

What MEDICATIONS are you currently taking? _____

What Dermatology MEDICATIONS have you tried in the past? _____

Do you have an allergy to Bacitracin®, Polysporin®, Neosporin® or any other topical antibiotic cream? NO YES

Are have an allergy to band-aids, adhesive, tape, or latex? NO YES

Female patients only: Are you pregnant or breast-feeding? NO YES

Female patients only: Do you take any kind of birth control? NO YES

Last Sun Exposure (tanning / outdoor activity): _____

Do you use tanning beds or spray-on tanning? NO YES Last exposure:_____

How does your skin react when exposed to the sun? (please circle ONE of these six choices below)

Always Burns & Never Tans	Burns Easily & Tans Minimally	Sometimes Burns & Slowly Tans	Burns Minimally & Usually Tans	Rarely Burns & Tans Well	Never Burns & Always Tans

What is the MAIN REASON you are coming in to be seen today? _____

What other items would you like to address today? _____

_____

_____

Would you like information on:

Botox **Filler** **Latisse** **Chemical Peels**

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---------- HIPPA PATIENT CONSENT and OFFICE POLICIES----------

Our office is committed to protecting the privacy of your medical information. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and updated in 2013) is a federal law that governs the use and disclosure of a person's health information. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The Notice contains a "Patient Rights" section describing your rights under the law. The following statements cover the basics of your rights as a patient under HIPAA:

- Our office has a "Notice of Privacy Practices" and you have the right to review a detailed copy of our Notice before signing this HIPAA Patient Consent.
- This "Notice of Privacy Practices" is available in our offices.
- Protected health information may be disclosed for treatment, payment, or health care operations.
- We reserve the right to change the terms of our "Notice of Privacy Practices" at any time.
- If we change our Notice, you may obtain a revised copy by contacting our office.
- You have the right to restrict the uses of your protected health information.
- You may revoke this HIPAA Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Additionally, it is the policy of this office to remind patients of their appointments. We may do this via live telephone calls, automated (TeleVox) appointment reminder calls, text messages, e-mails, U.S mail, and social media or by any means convenient to the practice. We may also send you other communications informing you of changes to office policy, new technology and specials that you might find valuable or informative. That said, contact will only come directly from us; we will never sell or trade your private information including phone numbers, e-mail address or mailing addresses. You may opt out of any or all communication measures any time by contacting us in writing. If you request a copy of your medical records you agree to pay an administrative fee in accordance with this office's policy and state rules/regulations. Once this fee is collected we will mail a copy of your records to the address of your choosing. We cannot email records to you. By signing this page you certify that you have read our HIPAA Patient Consent and have had the opportunity to review a more detailed version if so desired. Your signature also signifies that you agree with the above statements and this policy. Kirby Dermatology provides this form and information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (updated in 2013).

---------- FINANCIAL RESPONSIBILITY POLICY----------

Payments for all medical or cosmetic services are due prior to treatment. If you have health insurance we will not submit your visit to your insurance company for any cosmetic service, but will provide you with a copy of your super bill so you may submit it to them should you request it. Additionally, we will attempt to assist with any insurance questions you have but we are neither capable nor responsible to know all the specific details of your individual insurance plan including covered services, prescription coverage and yearly deductible requirements. Naturally, payment is required for all services rendered prior to service. We will submit your insurance for outside lab fees and you will be responsible for unmet deductible payment, non-covered services, and co-payments. I understand that Dedicated to Health accepts payment in the form of cash or credit card. My printed name and signature below signifies my understanding and willingness to comply with this policy and to authorize payment of my medical or cosmetic treatments or product purchases to Dedicated to Health Medical Group, INC.

---------- MISSED / LATE APPOINTMENT POLICY ----------

I understand that Dedicated to Health Medical Group,INC and their providers strive to treat all patients at their scheduled times and that I must provide at least 48 hours notice if I need to reschedule or am unable to make my aesthetic/cosmetic appointment. I understand that my credit card will be charged $100 for all missed appointments. I also understand that a deposit may be required to book appointments for medical and cosmetic services.

----------CONSENT FOR EXAMINATION AND TREATMENT ----------

I hereby authorize Dedicated to Health Medical Group, their licensed providers, their associate(s), and/or their staff to examine me (or the patient named on this form) and to administer any and all treatment that the provider or their associate(s) deem necessary.

My printed name & signature below certify that I have provided complete and accurate contact & medical information and that I have read, fully understand & completely agree with the HIPPA Patient Consent and Office Policies, Financial Responsibility and Missed / Late Appointment Policies contained in this document and I agree to Examination and Treatment.

X_____	**X**_____
Printed Name of Patient (or legal guardian)	**Date**
X_____	
Signature of Patient (or legal guardian)	