# DERMATOLOGY LASER AND PLASTIC SURGERY LLP

SHERRY LI, MD, PHD, F.A.A.D.
AMERICAN BOARD OF DERMATOLOGY

MR./MRS./MISS/MS.
PATIENT _____
Last Name First Name Middle Initial

ADDRESS _____
Number and Street

_____
City State Zip

HOME PHONE # ( ) _____ AGE _____ DATE OF BIRTH _____ SEX ____

SOC. SEC # _____ MARTAL STATUS [S] [M] [W] SPOUSE'S NAME _____

OCCUPATION _____ BUSINESS PHONE # ( ) _____

FAX # _____ CELL PHONE # ( ) _____

EMAIL _____

REFERRED BY

NAME _____ ( ) Dermatologist
( ) Plastic Surgeon

ADDRESS _____ PHONE # ( ) _____

FAMILY PHYSICIAN _____ OB/GYN _____

ADDRESS _____ Address _____

PHONE # ( ) _____ PHONE # ( ) _____

NATURE OF PROBLEM _____

SEND REPORT ☐

## RESPONSIBLE PARTY INSURANCE INFORMATION

| FIRST INSURANCE | SECOND INSURANCE |
|---|---|
| COMPANY NAME _____ | COMPANY NAME _____ |
| MAILING ADDRESS FOR CLAIMS _____ | MAILING ADDRESS FOR CLAIMS _____ |
| _____ | _____ |
| INSURED'S NAME _____ | INSURED'S NAME _____ |
| INSURED'S BIRTH DATE _____ | INSURED'S BIRTH DATE _____ |
| SOC. SEC. # _____ | SOC. SEC # _____ |
| POLICY # _____ | POLICY # _____ |
| GROUP # _____ | GROUP # _____ |
| CO PAY AMOUNT $ _____ | CO PAY AMOUNT $ _____ |

**- TURN OVER -**

**PLEASE CIRCLE THE APPROPRIATE ANSWER:**

Have you ever been treated for any of the following?

duodenal or peptic ulcer Yes No

tuberculosis or lung disease Yes No

heart murmur/disease Yes No

high blood pressure Yes No

blood clot Yes No

kidney disease Yes No

hepatitis Yes No

emotional disorder Yes No

diabetes Yes No

bleeding disorder Yes No

joint replacement Yes No

immuno deficiency disorder Yes No

artificial heart valve Yes No

Do you take antibiotics prior to surgery? Yes No

Have you been hospitalized? Why? Yes No

**Are you allergic to any medications?** Yes No

**(if yes, please list)**

Do you take aspirin? Yes No

Do you take blood thinners? Yes No

Have you ever had

difficulty with the healing of wounds? Yes No

excessive bleeding when cut? Yes No

overgrown scars or keloids? Yes No

x-ray treatment for acne or other skin conditions? Yes No

Do you have a **PACEMAKER**? Yes No

Has anyone in your family had a malignant melanoma or other skin cancer? Yes No

Do you and/or other family members have large or unusually numerous moles? Yes No

Do you have any pigmented spots that have changed in size, color, thickness, texture, etc.? Yes No

Are there any areas on your skin which bleed or will not heal? Yes No

**FOR FEMALES**

Are you now pregnant, planning a pregnancy in the near future, or nursing a child? Yes No

**(if yes, please specify)**

**NOTE:** I hereby acknowledge that this facility will not honor any DNR (do not resuscitate) directive that may be in place in other facilities.

Date _____ Signature of Responsible Party _____

# Dermatology Laser & Plastic Surgery, L.L.P.
# Universal Medication Form

Patient Name:_____ Date of Birth:____/____/____ Today's date ___/___/___

**Do you have any Allergies to Medication? ☐Yes or ☐ No** If yes, list allergies and reactions to medication below

_____

Do you currently take any Medications? Yes ☐ No ☐ If yes, please list all medications that you are currently taking. Include eye drops, inhalers, contraceptives, patches that contain medication, over-the counter medications (e.g., aspirin,antacids) and dietary/herbal supplements (e.g., vitamins, gingko biloba). Also include medications taken as needed ( e.g., nitroglycerin).

**FOR OFFICE USE ONLY**

| Date | Name of Medicaton & Dose (e.g., mg, drops) | Directions (e.g., am, pm) | Reasons for taking/ Prescribing MD name | Date Stopped | Medication given in office | Contra-indicated? |
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