MEDICAL HISTORY

PATIENT: ______________________________ ***GENDER***: ________ ***HEIGHT***:________ ***WEIGHT***:________ ***DATE OF BIRTH***: ______

REASON FOR TODAY'S VISIT:

1. ____ 2. ____

Are you allergic to any medications? ☐ ***YES*** ☐ ***NO*** ***If yes, list:***

1. ____ 3. ____

2. ____ 4. ____

List ALL Medications AND their dosages you are taking: including prescription / non-prescription drugs, vitamins, herbs, dietary or any other supplements (if none, please write NONE)

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

List ALL skin care products you are currently using (including soaps, cleanser, creams, lotions, retinols, antioxidants, SPF, etc)

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

Past Medical History: (Please Mark all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic Cough
- ☐ COPD
- ☐ Phlebitis
- ☐ Glaucoma
- ☐ High Cholesterol
- ☐ Other:
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Pacemaker/Defibrillator
- ☐ Artificial Heart Valve
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Arthritis/Joint Deformity
- ☐ Parkinson's Disease
- ☐ Dementia/Alzheimer's Disease
- ☐ Diabetes (Type_____)
- ☐ Thyroid
- ☐ Kidney
- ☐ Bladder
- ☐ Stomach
- ☐ Bowel
- ☐ Fainting
- ☐ Seizures/Epilepsy
- ☐ Hepatitis (Type______)
- ☐ Herpes of the Lip (cold sores)
- ☐ Genital Herpes
- ☐ Syphilis
- ☐ Genital Warts
- ☐ Cancer
  Type: _______________

____

Skin Disease History:

- ☐ Acne
  Use of isotretinoin? Y N
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Other:
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Oily Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma Skin Cancer
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

____

Do you have a family history of MELANOMA? Please circle: YES NO

If yes to melanoma, which relative(s)? ____

Do you have a family history of Skin Cancer? Please circle: YES NO

If yes, which relative(s) and what type of skin cancer? ____

PLEASE CONTINUE ON TO BACK PAGE

Surgical Procedure History (If none, please write NONE)

Date	Procedure	Any Complications ?

Please List any cosmetic procedures you have had (including any facials, chemical peels, surgical enhancements, fillers, implants, laser, intense pulsed light, radiofrequency, infrared, therapeutic ultrasound, electrical stimulation, Botox, microdermabrasion, etc)? (If none, please write NONE)

Date	Procedure	Area Treated	Rank Success 0-10

Social History:

Alcohol: ☐ None ☐ Less than 1 drink a day ☐ 1-2 drinks per day ☐ 3 or more drinks per day ☐ Beer ☐ Wine ☐ Hard

Liquor Tobacco Use: ☐ Daily Smoker ☐ Someday Social Smoker ☐ Former Smoker ☐ Smokeless Tobacco

If current smoker: ____ packs per day If you are a former smoker, how long ago did you quit? ____________

Recreational, illicit or IV drug use: ☐ YES ☐ NO If yes, type and how much/often? ______________________________

HIV (AIDS) exposer: ☐ YES ☐ NO

Have you ever had dental anesthesia (Novocain)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

Have you ever had local anesthesia (Xylocaine, Marcaine) ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

Any Artificial Joints? ☐ YES ☐ NO If yes, please specify: ____________________________________

Do you bleed easily? ☐ YES ☐ NO

When you are exposed to the sun do you: ☐ Tan Only ☐ Tan and Burn ☐ Burn

Do you have any of the following scarring reactions: ☐ Scar Easily ☐ Excessively ☐ Keloid ☐ Discoloration ☐ Minimal Reaction

Do you have a family history of any specific skin, hair, or nail diseases? ☐ YES ☐ NO

If yes, please explain ____

- ***Female Only Questions:***
  - Do you have regular periods? ☐ YES ☐ NO ***Last Menstrual Period:*** ________________________
  - Are you going or have gone through Menopause ☐ YES ☐ NO
  - Are you pregnant or breastfeeding? ☐ YES ☐ NO
  - Have you missed any periods in the last year? ☐ YES ☐ NO
  - Have you or anyone in your family have any history of endometriosis or ovarian cysts? ☐ YES ☐ NO
    - If Yes, Who ______________________________

Have you ever had the Pneumonia Vaccine? ☐ YES ☐ NO ***Did you have the Flu Vaccine this season?*** ☐ YES ☐ NO

Have you ever tested positive for COVID? ☐ YES ☐ NO ***Have you had the COVID Vaccine?*** ☐ YES ☐ NO

If yes, which one? ☐ Pfizer ☐ Moderna ☐ J&J ☐ None

What is your occupation? ____

What are your hobbies? ____

Pharmacy Preference: **____ Location: __________________________**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Hubbell Dermatology & Aesthetics, APMC may use and disclose protected health information (PHI) about me to carry out and exchange information necessary for treatment, payment or operations of health care business (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Hubbell Dermatology & Aesthetics, APMC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Hubbell Dermatology & Aesthetics, APMC may mail or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, including, but not limited to, appointment reminder cards and patient statements.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hubbell Dermatology & Aesthetics, APMC 's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hubbell Dermatology & Aesthetics, APMC may decline to provide treatment to me.

By signing this form, I hereby acknowledge receipt of Hubbell Dermatology & Aesthetics, APMC Notice of Privacy Practices with respect to the patient. At any time, I have the right to review the Notice of Privacy Practices that may be obtained by forwarding a written request to Hubbell Dermatology & Aesthetics, APMC Privacy Officer at 309 Settlers Trace Blvd., Ste. 100, Lafayette, LA 70508 or you may view them on our website at www.skinexpert.com.

Please list whom you give our office permission to discuss your medical and financial information with. Please write "None" if you do not give us permission to speak with anyone.

	Name:	**Relationship:**
1)	______________________________	____________________
2)	______________________________	____________________

______________________________ ____________________
Signature of Patient or Legal Guardian Date

____
Patient's Printed Name

FINANCIAL POLICY

- Payment is required for all services at the time they are rendered (unless you have made prior arrangements) Hubbell Dermatology & Aesthetics, APMC accepts payment in the form of cash, checks, and all major credit cards
- If a check is returned to the office due to insufficient funds, the original check amount plus a $25 returned check fee
- If a patient's balance has reached 90 days past due, your account will be turned over to an outside collection agency for further action. The patient may be discharged from the practice because of financial non-compliance.
- Please help us better serve you and our other patients by keeping all scheduled appointments. If you must change an appointment, please do so before 48 hours prior to your scheduled appointment time. ***The charge is $50.00 for any missed appointment without receiving a notice from you prior to 48 hours of your appointment.***
- Lab tests and/or Pathology specimens sent to outside laboratories will be billed separately from Hubbell Dermatology & Aesthetics' charges. The laboratory will bill you and/or your insurance company separately for their charges.

PATIENTS WITH PRIVATE INSURANCE/MEDICARE

Hubbell Dermatology & Aesthetics, APMC is pleased to participate in several different insurance plans. While we are pleased to be able to participate in these plans, it is impossible for our office staff to be aware of each plan's specific and frequently changing requirements. It is the patient's responsibility to inform Hubbell Dermatology & Aesthetics, APMC of specific limitations set forth by their insurance plan(s). It is your responsibility to verify that we are a member of your network before presenting to our office for treatment. It is in your best interest to verify this by calling the customer service number on your insurance card before being seen.

If we participate with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. You will be responsible at the time of service for payment of your annual deductible, co-payments, and any non-covered or cosmetic charges. In the event that we are not aware of a charge that is not covered by your plan, you will be billed after we obtain a denial from your insurance carrier.

For those patients who have chosen a medical insurance plan that we do not have a contractual relationship with, we require payment in full at the time of service. You will be responsible to file the charges for your treatment with your insurance company.

We are Medicare participating providers. We will bill Medicare and Medigap (Supplement) carriers. You will be responsible at the time of service for payment of the annual deductible, co-payments, co-insurance (20%) and charges for non-covered or cosmetic services.

FINANCIAL POLICY FOR COSMETIC PROCEDURES AND PRODUCTS

The patient is financially responsible for all cosmetic procedures. This office ***does not*** bill insurance companies for cosmetic procedures or skin care products and the following policies are required for cosmetic procedures.

- A deposit is required to schedule a cosmetic procedure and the remaining cost of the procedure is required at the time the procedure is performed.
- Payment can be made by cash, cashier's check, personal check, all major credit cards, Green Sky, or Care Credit Financing.
- I understand that any quote given will be honored for six (6) months from the date of the quote
- All Product Sales or final. Returns or Exchanges will not be accepted.
- **Two business days' notice (48 hours) is necessary to cancel a cosmetic appointment otherwise, the deposit is forfeited.** ***(Please note that our office is closed on weekends and holidays!)***

Your signature below signifies that you understand our financial policy and agree to the terms of your responsibility regarding charges incurred at this office

PATIENT SIGNATURE OR GUARDIAN ___________________________________ **DATE** ________________________

PRINT PATIENT NAME ____

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