Additional Patient Information for our Records Date:_____

Patient DOB ____/____ /____ ☐Male ☐ Female

Patient Name_____
First Middle Last

E-Mail Address_____

Primary on Insurance_____ DOB ____/____ /____
First Middle Last

Home Phone _____-_____-_____ Cell Phone _____-_____-_____ Work Phone _____-_____-_____

Preferred Language:_____ Ethnic Group: Hispanic Non-Hispanic Refuse to Answer

Race: American Indian/Alaskan Native Asian Black or African American Middle Eastern
Hawaiian or Pacific Islander White Unknown

How did you hear about us? (please circle one)

°Billboard	°Social Media: Facebook/Instagram	
°Friend	°Long Term Patient	
°Hairdresser/Barber	°Pharmacist	
°Health Fair	°Physician Referral	
°Insurance	°Radio	
°Internet Search	°Relative	°Other_____

Family Doctor _____

Preferred Pharmacy Name:_____City_____Street_____

I have previously seen the following providers at this office:

☐ Dr. Anderson ☐ Dr. Bekas ☐ Dr. Peacock ☐ Michelle Hicks, NP

Like and Follow us on Facebook and Instagram

Lifetime Skin Care Centers lifetime_skin_care_centers

Patient Name_____ **Date of Birth** _____/_____/_____

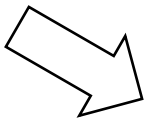
Please do not leave blank questions- **If something does not apply please circle NONE**

Past Medical History (Please circle all that apply) **NONE**

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Stroke (cerebrovascular accident)
COPD (chronic obstructive lung disease)
Coronary Artery Disease (coronary arteriosclerosis)
Depression
Diabetes
Elevated blood pressure
End-Stage Renal disease
Epilepsy
GERD (gastroesophageal reflux disease)
Hearing Loss
HIV/AIDS
Hypercholesterolemia (high cholesterol)
Hyperthyroidism
Hypothyroidism
Inflammatory disease of liver (Hepatitis)
Leukemia
MRSA
Lymphoma
Breast Cancer
Colon Cancer
Prostate Cancer
Radiation Treatment
Bone marrow transplant

Past Surgical History (Please circle all that apply) **NONE**

Appendectomy (appendix removed)
Breast Biopsy
Removal of Bladder
Removal of Gallbladder (cholecystectomy)
Coronary Artery Bypass (CABG)
Diverticulitis
Kidney Transplant
Basal Cell Treatment
Melanoma Treatment
Squamous Cell Treatment
Colon Resection (colectomy)
Removal of Kidney (nephrectomy)
Hysterectomy
IBS (irritable bowel syndrome)
Kidney Stones
Liver Transplant
Lumpectomy of Left Breast
Lumpectomy of Right Breast
Prostate Cancer
Mastectomy of Left Breast
Mastectomy of Right Breast
Heart Valve Replacement
Removal of Testicles (orchiectomy)
Removal of Pancreas (pancreatectomy)
Removal of Prostate (prostatectomy)
Removal of Spleen (splenectomy)
Biopsy of Skin
Replacement of Left Hip
Replacement of Left Knee
Replacement of Right Hip
Replacement of Right Knee
Heart Transplant
Tubal Ligation



Other Surgeries:_____
_____
_____
_____

Skin Disease History: (Please Circle all that apply) **NONE**

Acne	Malignant Melanoma
Actinic Keratoses	Psoriasis
Asthma	Seasonal Allergies
Basal Cell Skin Cancer	Squamous Cell Carcinoma
Poison Ivy	Sunburn
Atypical Moles	
Eczema	Other_____

Do you wear sunscreen? Yes No
If yes, what SPF?_____
Do you tan in a tanning salon Yes No

Do you have a family History of Melanoma? Yes No
If Yes, which relative(s)? _____

Medications: (Please list all current medications or attach a copy)

_____
_____
_____
_____
_____

Allergies & Reactions: (Please enter all **MEDICINE** allergies and the reaction you get)

_____
_____
_____

Cigarette Smoking: Never Smoked Former Smoker (start/stop dates) Currently Smokes (start date/how many years total)

_____ _____

Social History

Alcohol Use: None Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day

Occupation/Hobbies:

Patient Employer_____Occupation_____

Hobbies_____

Review of Systems:

Are you CURRENTLY experiencing any of the following:

Problems with bleeding	Problems with healing	Problems with scarring	Immunosuppression

NONE

Alerts:

Do any of the following apply to you?

Medication allergy	Blood thinners	Pregnancy or planning pregnancy
Allergy to adhesive	Defibrillator	HIV positive or AIDS
Allergy to lidocaine	MRSA	Hepatitis
Allergy to topical antibiotics	Pacemaker	Insulin Pump
Artificial heart valve	Premedication prior to procedures	Cochlear Implant
Artificial joints in past two years	Rapid heartbeat with epinephrine	Nerve Stimulator

NONE

Payments Made Easy

Put your payment on "Automatic" And leave the rest to us!

- ✓ Free yourself of monthly check writing
- ✓ Save time and avoid lost and delayed payments in the mail
- ✓ Have record of payments on your bank or credit card statement
- ✓ Help eliminate paper waste and save on postage and checks

To sign up for automatic payments, simply fill out the information below and return with your payment.

Patient name: _____ **Account#:** _____ (OFFICE USE ONLY)

I authorize **Lifetime Skin Care Centers** to keep my signature on file and to charge my **credit/debit** or **health spending** card as indicated below:

Please check one option:

☐ **I would like to be charged the balance insurance does not pay automatically**

☐ **I would like to be charged monthly for the balance insurance does not pay:**

**Monthly Amount to be withdrawn (circle one): $25.00 $50.00 $75.00 $100.00 other amount $_____

**Monthly Payment date: _____

Last 4 digits of Credit Card on file: ___ ___ ___ ___ Email receipt: yes / no

Email address: _____

I authorize Lifetime Skin Care Centers to charge my payment to the credit/debit/HRA/HSA card account number shown above. I understand that the funds will be withdrawn after my insurance processes my claim and in accordance with the choice indicated above (if the monthly payment date falls on a weekend or holiday, my payment will be run the next business day). It is my responsibility to ensure sufficient funds are available in my account for these transactions.

This authorization will remain in effect until I instruct Lifetime Skin Care Centers to cancel or change it. I also understand that if my payment is declined for "non-sufficient funds" this service is subject to termination by Lifetime Skin Care Centers. I understand that Lifetime Skin Care Centers will ensure my privacy as it pertains to these transactions.

Signature _____ **Date** ____/____/_____

☐ card vaulted _____staff initials