



Center for Cosmetic Enhancement

Leonard Slazinski, MD, PA.
Diplomat, American Board of Dermatology

PATIENT INFORMATION SHEET

Patient Name: Last _____ First _____ MI _____

Local Address: _____ City _____ State _____ Zip _____

Out-of-state Address: _____ City _____ State _____ Zip _____

Hm. Phone (____) _____ D.O.B. ____/____/____ Age _____ SS # ____/____/____

Sex: F ___ M ___ Marital Status: Single ___ Married ___ Widowed ___ Divorced ___

Employer: _____ Wk. Phone (____) _____

Nearest Relative: _____ Relationship: _____

Address: _____ Phone (____) _____

Referring Physician: _____ Phone (____) _____

Family Physician: _____ Phone (____) _____

How did you hear of us?

- ___ Doctor ___ Yellow Pages ___ Sarasota Herald Tribune
___ Friend/Relative ___ West Coast Woman Magazine ___ Other: _____
___ Former Patient ___ Sarasota Magazine _____

PLEASE PRESENT UP TO DATE INSURANCE CARDS TO RECEPTIONIST

DOES YOUR DOCTOR NEED TO AUTHORIZE THIS VISIT FOR YOUR INSURANCE? Y or N

Our Policy Regarding Patient Financial Responsibility

Managed Care Plans. Our office files insurance claims for managed care groups with which we participate. We accept payments for covered services from these insurance plans in accordance with our contract. Our patients are responsible for applicable co-insurance and deductible amounts. Our patients are also responsible for any kind and all payments for services that are not covered by insurance. The patient is responsible for payment of amounts they owe at the time of service.

Medicare. Our office files insurance claims for Medicare on assignment. We accept Medicare allowable amounts as payment and the patient is responsible for charges applied to their deductible, any co-insurance and non-covered charges.

Other Insurance. If the patient's insurance is with a company with which we do not participate, the patient is responsible for payment of their bill at the time of service. We will, however, file non-assigned claims to these insurance companies as a courtesy to our patients.

Self Pay. All services are required to be paid in full at time of service.

Summary. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within the policies and guidelines of our patient's insurance plan. **It is, however, the responsibility of the patient to know and understand those policies and guidelines. It is also the responsibility of the patient to seek medical care only with physicians participating with their plan.**

I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visit. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any other outstanding account incurred by myself, or my dependents. Should legal action be required to secure payment of this account, I agree to pay a reasonable collection expense, all court costs and a reasonable attorney's fee incurred thereby.

I have read and understand the office policy stated above and agree to accept the responsibility described.

Patient / Responsible Party

Date

Record Release

I hereby authorize you to release to any physician, hospital, laboratory, or insurance company information including hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency syndrome (AIDS), or tests for HIV and records of any treatment or examination rendered to me during my treatment period.

Patient / Responsible Party

Date



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MEDICAL HISTORY

Date _____

Name _____ Age _____ D.O.B. _____

How did you hear about our office? _____

Reason for visit:

- ____ Facial Improvement/Rejuvenation
- ____ Hair Removal
- ____ Veins/Broken Blood Vessels
- ____ Skin Growths/Moles/Brown Spots
- ____ Botox
- ____ Acne/Blemish Treatment
- ____ Other _____

Skin Type (when exposed to the sun w/o protection for one hour)

1. Always burns, never tans _____
2. Always burns, sometimes tans _____
3. Sometimes burns, sometimes tans _____
4. Always tans _____
5. Hispanic, Asian, Mediterranean, Middle Eastern, Indian _____
6. Black _____

What outdoor activities do you engage in? _____

When were you last exposed to the sun/tanning booth? _____

Do you use chemical suntanning lotions/sunblocks? _____

Have you ever had any surgery or x-ray therapy? ___Yes ___No

Have you ever had cosmetic surgery previously? ___Yes ___No

Have you ever had vein therapy previously? ___Yes ___No

What medications are you taking? _____

Aspirin? _____

Hormones/Birth Control Pills? _____

Herbal preparations (St. John's Wort, etc.)? _____

Do you smoke? _____ # per day _____ How long? _____

Do you drink alcohol? _____ Amount per week? _____

Allergies: _____

MEDICAL HISTORY

Female Medical History:

Menstrual Periods? ___ Yes ___ No Regularly? ___ Yes ___ No

Are you pregnant? _____ Number of Pregnancies? _____

Number of Live Births? _____

Birth Control Method? _____

Birth Control Pill? (Brand?) _____

Menopausal symptoms? ___ Yes ___ No Hot Flashes? ___ Yes ___ No

Family Medical History (check if applicable)

| | | |
|---------------|-----------------|--------------------|
| ___ Diabetes | ___ Hay Fever | ___ Varicose Veins |
| ___ Asthma | ___ Eczema | ___ _____ |
| ___ Arthritis | ___ Cancer | ___ _____ |
| ___ Psoriasis | ___ Skin Cancer | ___ _____ |

Patient Medical History (check if applicable)

| | | |
|---------------------------------|------------------------|--------------------------|
| ___ Diabetes | ___ Phlebitis | ___ Gout |
| ___ Hypertension | ___ Hoarseness | ___ Glaucoma |
| ___ High Blood Pressure | ___ Arthritis | ___ Cataracts |
| ___ Recent Weight Loss/ Gain | ___ Thyroid Disease | ___ Prostate Problems |
| ___ Migraine Headaches | ___ Anemia | ___ Cancer Type: _____ |
| ___ Neurologic Disease | ___ Easy Bruising | ___ Skin Cancer |
| ___ Seizures/Epilepsy | ___ Hepatitis | ___ Peptic Ulcer Disease |
| ___ Mental Illness | ___ Stroke | ___ Colitis |
| ___ Depression | ___ Lung Disease | ___ Venereal Disease |
| ___ Coronary Artery Disease | ___ Asthma | ___ Herpes |
| ___ Heart Murmur | ___ Hay Fever | ___ Gonorrhea |
| ___ Palpitations | ___ Allergies | ___ Chlamydia |
| ___ Irregular Heartbeat | ___ Nose bleeds | ___ HPV/Warts |
| ___ Kidney Disease | ___ Lupus | ___ Hair Loss |
| ___ Kidney Stone | ___ Eczema | ___ Hives |
| ___ Varicose Veins | ___ Keloids | ___ Tuberculosis |
| | ___ Excessive Scarring | ___ AIDS/HIV |
| | ___ Psoriasis | |

Other Medical Condition Not Mentioned Above _____

Assistant's Signature

Date

Patient's Signature

Date