Last Name: _____ Middle Initial: _____ First Name: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____Cell Phone: _____
Occupation: _____ Office Phone: _____
SSN: _____ Marital Status: _____ Sex: M/F
Birthday: _____ Age: _____ Email: _____

Emergency Contact

Name: _____ Phone: _____
Relationship: _____

Primary Physician

Name: _____ Phone: _____

Pharmacy

Pharmacy Name: _____ Location: _____

Referred By

Doctor: _____ Friend: _____ Internet: ___ Insurance: ___ Other: _____

Insurance Information

Primary Insurance: _____ Policy Holder: _____ Relationship: _____
Insured DOB: _____ Insured SSN: _____
Policy #: _____ Group #: _____
Policy Holder Address: _____ Same as Above: ____
Secondary Insurance: _____ Policy Holder: _____ Relationship: _____
Insured DOB: _____ Insured SSN: _____
Policy #: _____ Group #: _____

Date: _____

Medical History

Name: _____ DOB: _____
Reason for today's visit: _____

Past Medical History: (Please check all that apply)

___ Asthma
___ Autoimmune Disease
___ Arthritis (specify)_____
___ Kidney Disease
___ Hepatitis
___ High Cholesterol
___ Radiation (specify)_____
___ Seizures
___ Pacemaker
___Organ/ Bone Marrow Transplant
___ Anxiety
___ Depression
___ Diabetes
___ GERD
___ HIV/ AIDS
___ Hypertension
___ Thyroid Problems (specify)_____
___ Chemotherapy (specify)_____
___ Stroke
___ Defibrillator
___ Artificial Joint
____ History of fainting

Other: _____

Skin History:

___ Skin Cancer (specify)_____
___ Melanoma (location/ year) _____
___ Eczema
___ Atypical Moles
___ Hives
___ Seasonal Allergies
___ Scarring/ Keloids
___ Actinic Keratosis (pre- cancers)
___ Cancer (specify) _____
___ Psoriasis
___ Herpes Simplex (cold sores)
___ MRSA
___ Bleeding/ Clotting Disorders

Family History of Melanoma/ Skin Cancer: Yes/ No (specify) _____
Past Surgical History/ Hospitalizations:
_____
Medications (prescriptions, over the counter, vitamins, supplements):
_____
Allergies: _____
Allergies to Bacitracin/ Latex/ Epinephrine/ Adhesives: (circle if applicable) Yes/ No

Marital Status (Circle One):
Single/ Married/ Divorced/ Domestic Partner/ Separated/ Widowed

Social History:
Tobacco: Yes/ No Former smoker: Yes/ No If yes, how much? _____
Alcohol: Yes/ No/ Occasional If yes, _____ drinks per day/ week
IV Drugs: Yes/ No If yes, what? _____ How often? _____

Sun History:
Do you wear sunscreen? Yes/ No If yes, what SPF? _____
Have you ever used a tanning booth? Yes/ No If yes, how often? _____
Have you had sunburns in the past? Yes/ No If yes, estimate how many? _____

Female Patients:
Are you pregnant? Yes/ No Date of last menstrual period? _____
Are you nursing? Yes/ No

Patient Authorization for Release of Protected Health Information

Patient Name: _____ DOB: _____ Date: _____

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and accountability Act. This Federal Law prohibits any staff member of Sperling Dermatology, LLC from discussing appointments, medications, test results, or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for or about them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are a college student away at school and your parents assist you with prescriptions and appointments.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results on your behalf, please indicate their name(s) below. Only these individuals will be provided with information.

I have the right to revoke this authorization, in writing, at any time, except to the extent Sperling Dermatology, LLC has taken action in reliance on this authorization.

Name of individual: _____ Relationship: _____
Phone Number: _____

Name of individual: _____ Relationship: _____
Phone Number: _____

Signature of Patient OR Parent/ Guardian: _____ Date: _____

I also consent for Sperling Dermatology, LLC to contact me by the following methods:

Leave message regarding *medical information* on:
home phone ___ work phone ___ cell phone ___ None ___
Leave message regarding *appointments* on:
home phone ___ work phone ___ cell phone ___ None ___

Signature: _____ Date: _____
Responsible Party Name *(if different from patient)* _____ Signature: _____
Relationship to patient: _____

I hereby authorize Sperling Dermatology, LLC to release any of my medical information necessary to process this claim and all future claims and also authorize payments directly to the provider. A photocopy of this assignment shall be valid as the original.

I certify that I am financially responsible for all charges including the deductible, co- payment, charges for cosmetic services, and collection fees not covered by your insurance company.

I hereby voluntarily consent for examination and treatment by Sperling Dermatology, LLC.

Signature: _____ Date: _____

Responsible Party Name (*if different from patient*) _____ Signature: _____

Relationship to Patient: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

This notice describes how medical/ protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP).

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communication.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of the Notice.

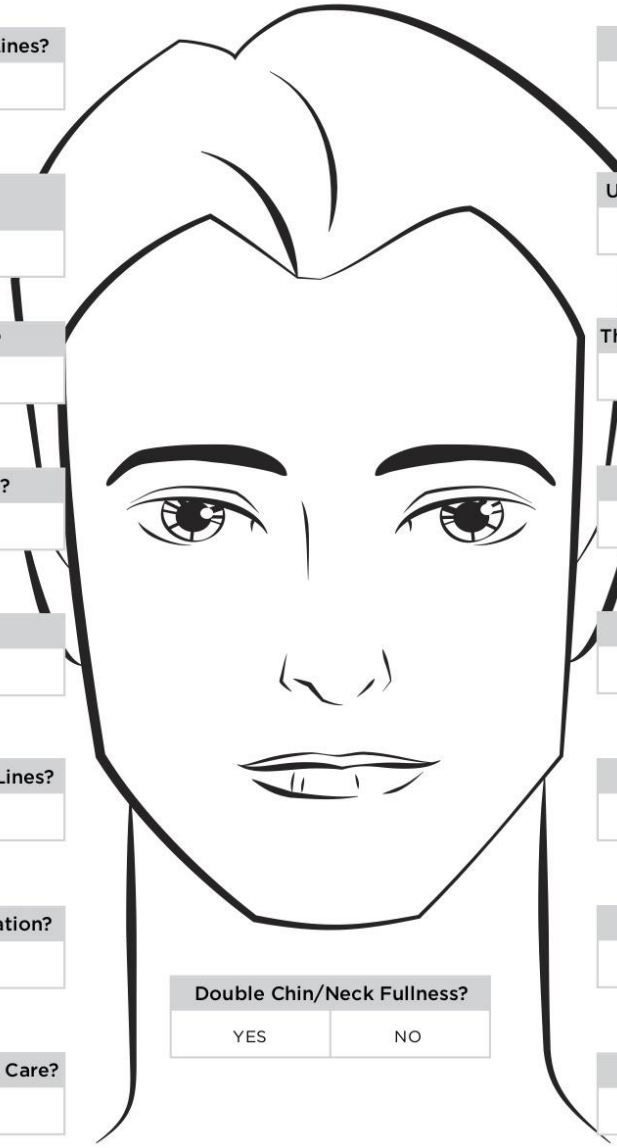
We want to assure you that your medical/ protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

I hereby acknowledge receipt of Sperling Dermatology, LLC's Notice of Privacy Practices.

Name: _____ Signature: _____
Date: _____
Parent/ Guardian (print): _____Relationship to patient: _____
Signature: _____ Date: _____

Patient Concerns

NAME	DATE
EMAIL	PHONE



Forehead Lines/Frown Lines?	
YES	NO

Improve Texture of Skin/Large Pores?	
YES	NO

Facial Volume Loss?	
YES	NO

Nose-to-Mouth Lines?	
YES	NO

Lips/Volume Loss	
YES	NO

Lip Lines/Lipstick Bleed Lines?	
YES	NO

Neck and Chest Discoloration?	
YES	NO

Are You Interested in Skin Care?	
YES	NO

Crow's Feet?	
YES	NO

Under Eye Circles/Lines/Bags?	
YES	NO

Thin, Short or Lightened Lashes?	
YES	NO

Brown Spots/Freckles?	
YES	NO

Broken Blood Vessels?	
YES	NO

Acne Scaring/Facial Scars?	
YES	NO

Red Spots/Flushing?	
YES	NO

Texture/Saggy Skin?	
YES	NO

Double Chin/Neck Fullness?	
YES	NO

Please add any additional concerns not listed: _____