LAUB DERMATOLOGY & AESTHETICS DAVID A. LAUB, M.D., A Professional Corporation
591 REDWOOD HWY. #2210 MILL VALLEY, CA 94941 (415)381-6661 Fax (415) 381-6695

PATIENT INFORMATION

Date__________________________ Male____ Female____ **Date of Birth**___/____/______ Age______________

Patient Name____ Nickname:___________________________________
Last First M.I.

Telephone number: ( )____ Work Phone ( )_____________________________________

Mailing Address____ Social Security #___________________________________

City__________________________________State___________Zip____________

E-Mail ____Please print clearly

________Please check here if you do not want notifications or practice updates via e-mail

Marital Status_____________Occupation_____________________________Employer_________________________________

In Case of Emergency notify: ____ Phone( )______________________________

INSURANCE INFORMATION

Name of insured subscriber (Guarantor)____Subscriber D.O.B. ______/______/______

Complete Mailing Address of guarantor if different from above :

Address____City_________________________State_____Zip________Phone#___________________

Insurance Carrier____________________________________ Group/plan#_________________________ID#_______________________________________

Claim Address ___________________________________City _______________________State______ Zip_____________ Phone#____________________

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to my physician David Laub, M.D. (APC) I understand I am financially responsible for non- covered services and also authorize my physician to release any information requested by my insurance company.

IF PATIENT IS A MINOR: Name of parent or legal guardian____
The adult / guardian who brings the child will be responsible for all copayments and deductibles. We do not forward bills to other parties. Guarantor insurance information above must be completed.

SIGNATURE____ Date_________________(If minor patient signature of parent or legal guardian)

NOTICE OF PRIVACY PRACTICE: With my consent, David A. Laub M.D. (APC) including his staff, may phone or/fax a designated location, and leave a message on voice mail, or in person, in reference to any item that assists the practice in carrying out treatment, payment, and healthcare operations. This may pertain to, but is not limited to the following: appointment reminders, clinical care, and insurance items. I understand that I may request to review the Notice of Privacy Practice information for David A. Laub M.D. (APC). For a complete HIPAA Privacy Policy please see our HIPAA NOTICE.

YES / NO (please circle one) I AUTHORIZE LAUB DERMATOLOGY & AESTHETICS AND STAFF TO LEAVE a message regarding my PROTECTED/PRIVATE HEALTH INFORMATION ON THIS PHONE NUMBER ONLY: Specific telephone number: ( )____

YES / NO (please circle one) I AUTHORIZE LAUB DERMATOLOGY & AESTHETICS AND STAFF TO SPEAK TO or LEAVE A MESSAGE WITH THE PERSON NAMED BELOW REGARDING MY PROTECTED/PRIVATE HEALTH INFORMATION

(list person's name please print)____ Telephone number ( )_____________________________________

Signature____ Date____________________________________

PATIENT REFERRAL INFORMATION

Primary Care Physician Name____

Phone # ( ) ____ FAX #____

If you were referred by a friend may we thank him or her? Yes / No Name____

How did you learn about our office? (Please ck one) _______ Doctor _______ Internet/Website _______Insurance _______Yelp _________Other

MEDICAL RECORD INFORMATION

Patient Name_____________________________ Nickname______________________ **Date of birth**____________________

Please list the names of other family members seen by the doctor____

Reason for today's visit ____

____

Preferred Language: __________________________**Race:**________________ **Ethnic Group**:__________________________

Pharmacy Name: ____

Phone#: _________________________________ **FAX#** _______________________**City or Zip code**:___________________

PAST MEDICAL HISTORY: (please circle all that apply)

Anxiety
Arthritis
Blood Clots
Coronary Artery Disease
Depression
Diabetes
G.I. Ulcers
Glaucoma
Heart Attack
Hepatitis B, C

Irregular Heart Beat
Leukemia
Lymphoma
Organ Transplantation
Phlebitis
Radiation Treatment
Seizures
Stomach Ulcers
Stroke
Thyroid Problems

High Blood Pressure
HIV/AIDS
High Cholestrol
Thyroid Problems
Tinnitus
Tuberculosis
NONE
OTHER:__________________________

PAST SURGICAL HISTORY:

Please list all past surgical history:____

SKIN DISEASE HISTORY: (Please circle all that apply)

Acne
Asthma
Blistering Sunburns
Eczema
Flaking or Itchy Scalp
Hives

Actinic Keratoses
Basal Cell Skin Cancer
Dry Skin
Fever Blister / HSV
Hay Fever/Allergies
Melanoma

Precancerous Moles
Squamous Cell Skin Cancer
Psoriasis
Pigmentation disorders

Do you wear Sunscreen? Yes No If yes, what SPF? ______________________

MEDICATIONS: (Please list all current medications and dose, vitamins etc)

____

ALLERGIES: (Please list all allergies)

____

If you have had any of these procedures previously or have interest in learning more about the corrective treatments available below, please circle all that apply.

Acne Scarring	Blood Vessel / Rosacea Treatment	Botox / Dysport
Blotchy Skin	CoolSculpting / Fat reduction	Chin / Neck wrinkles
Chemical Peels	Facial fillers	Hair Removal
Laser Treatments	Length /fullness of eyelashes	Leg Vein Treatment
Pigmentation Treatment	Skin Rejuvenation for aging skin	Skin Care Advice

SOCIAL HISTORY: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently Smokes	None
Has smoked in the past	less than 1 drink per day
Never smoked	1-2 drinks per day
Former smoker	3 or more drinks per day

Please list the Skin Care Products you are currently using: (Please circle all that apply)

Moisturizer Acne Treatment products Antioxidants Retinoids other____

____

WOMEN: Are you currently pregnant? YES / NO Trying to get pregnant? YES / NO Currently nursing? YES /NO

REVIEW OF SYSTEMS: (Please circle all that apply)

Problems with bleeding	Immunosuppression
Problems with healing	Thyroid Problems
Problems with scarring	Fever or chills
Rash	Joint aches
Rapid heartbeat with epinephrine	

ALERTS: (please circle all that apply)

Allergy to Adhesive	Allergy to lidocaine
Allergy to topical antibiotics	Allergy to topical anesthetic
Allergy to Latex	Artificial Heart Valve
Artificial joint replacement	Blood thinners
Defibrillator	Faints when given shots
Hepatitis A, B, C	HIV / AIDS
MRSA	Pacemaker
Require antibiotics prior to a surgical procedure	Rapid heart beat with epinephrine
Fever Blisters	
History of MELANOMA	

Do you have a family history of Melanoma Yes No If yes, which relative(s)?____