

To use this form you must have Acrobat Reader 5 or greater installed.

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-To enter in text, click in the area you wish to type in and begin typing.

-To check off choices on the form, click on the area you'd like to check.

- To send the completed form to our office, click “Submit” at the bottom of the last page.

- Feel free to print out a copy of the form before you send it to retain for your records.

If you experience difficulty submitting this form you can also print the blank form, fill out with black pen and bring the form to the office at the time of your appointment. If you do not have a printer you can fill out the form at the office at the time of your appointment.

Please fill out the form as completely as possible, and if you have any questions about this form please contact your doctor.

For your protection:

This form is hosted on a secure server and can only be viewed by our office. Please feel confident in filling out this form, as all of your information will be kept safe at every step of the process. *Your form will not be sent via email at any time to ensure the complete security of your information.*

Ritacca Laser Center

Welcome To Our Office! Please complete the following confidential information. If you would like assistance completing this form, our staff will be happy to help you.

PLEASE PRINT LEGAL NAME

DATE: _____

Mr. Mrs. Ms. Miss Dr.

FIRST NAME: _____ MI: _____ LAST NAME: _____ SEX: M F

PREFERRED NAME: _____ DATE OF BIRTH: _____ AGE: _____

MAILING ADDRESS _____ CITY/STATE/ZIP: _____ / _____ / _____

HOME PHONE: _____ DAY PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ SOCIAL SECURITY #: _____

PRIMARY CARE PHYSICIAN'S NAME: _____ PHONE NUMBER: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

SPOUSE'S NAME: _____

PARENT'S NAME (IF PATIENT IS A MINOR): _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

HOW DID YOU SELECT OUR OFFICE?

- Newspaper _____
- Radio _____
- Web Site _____
- Yellow Pages _____
- Friend _____
- Doctor _____
- Insurance Booklet _____
- Other _____

Payment is expected at the time services are rendered, including non-covered portions of insurance.

Insurance Company: _____

Insured Name: _____

Ins. Date of Birth: _____

Ins. S.S.: _____

I authorize the release of medical forms and procedures to the below persons. In case of emergency, these persons have the right to know what procedure was performed.

Contact 1: _____ Contact 2: _____ **Patient signature:** _____

NOTE:

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies! Please understand that financial responsibility for your account is yours, not your insurance company's.

SIGNED: _____

I authorize the release of any information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: _____

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: _____

RITACCA LASER CENTER

Medical History Questionnaire

Name: _____ Date: _____

Please circle P if you or F if a family member have experienced any of the following:

- | | |
|---------------------------------------|-------------------------------|
| P F Accutane Use | P F High Blood Pressure |
| P F AIDS / HIV | P F Kidney Problems |
| P F Anesthesia Allergy | P F Liver Disease |
| P F Anemia | P F Low Blood Pressure |
| P F Angina | P F Lupus |
| P F Arthritis | P F Memory Loss |
| P F Artificial Heart Valves of Joints | P F Nervousness |
| P F Asthma / Emphysema | P F Psychiatric Care |
| P F Back Problems | P F Radiation Treatment |
| P F Bleeding Disorders | P F Rashes |
| P F Cancer | P F Respiratory Disease |
| P F Chemical Dependency | P F Rheumatic Fever |
| P F Chest Pain | P F Seizure Disorder |
| P F Chronic Diarrhea | P F Shortness of Breath |
| P F Chronic / Frequent Cough | P F Sinus Problem |
| P F Circulatory Problems | P F Special Diet |
| P F Dentures / Bridges / Loose Teeth | P F Stroke |
| P F Diabetes | P F Swelling in Hands or Feet |
| P F Ear / Hearing Problems | P F Swollen Glands in Neck |
| P F Easy bruising | P F Throat Pain |
| P F Epilepsy | P F Tired Feet |
| P F Eye Problems | P F Tuberculosis |
| P F Fainting | P F Headaches |
| P F Ulcers | P F Heart Disease |
| P F Foot / Leg Cramps | P F Varicose Veins |
| P F Forgetfulness | P F Venereal Disease |
| P F Gout | P F Weight Loss / Gain |

List any medical problems or disease you are being treated for or have been treated for in the past. _____

How often do you exercise? _____

Current Height: _____ Current Weight: _____

Do you smoke? Y N # of years? _____ # of packs / day _____

Do you drink alcoholic beverages? Y N Amount consumed / week _____

Past Surgeries: _____

Past Hospitalizations: _____

Other Doctors Caring For You: _____

Medications You're Taking: _____

Pharmacy Telephone: _____

Are you allergic to:

- | | | |
|-------------------|--------------------|-------------------------------|
| Y N Adhesive Tape | Y N Iodine Seafood | Y N Latex |
| Y N Aspirin | Y N Novocaine | Y N Prior Anesthetic Problems |
| Y N Codeine | Y N Penicillin | |
| Y N Demerol | Y N Sulfa Drugs | |

Others _____

Signature _____ Date _____