Brentwood Dermatology
MEDICAL GROUP
Dermatology, Surgical Derm & Lasers

SOME OF OUR SERVICES

- Acne, Warts, Rashes
- Growth Diagnosis and Removal
- Skin Cancer Screening and Treatment
- Mole Removal with Minimal or No Scar
- Facial Redness
- Skin Tags
- Filling lower border of the eyes to bring back youthful look
- Botox, Restylane, Sculptra, Juvederm and Radiesse
- Photofacials
- Leg Vein
- Laser hair and tattoo removals

PATIENT INFORMATION

Today's Date _____ Birthdate _____ Age _____ ❒ Male ❒ Female

Patient's Name _____ Home Phone (____) _____ e-mail _____

Address _____ City _____ State _____ Zip _____

Social Security# _____ Driver's License # _____ State _____

In Emergency - Contact Name & Phone Number _____ Marital Status S M D W ❒

Patient Employer _____ Business Phone (____) _____ Cell Phone (____) _____

Address _____ City _____ State _____ Zip _____

Occupation _____ How Long Employed _____ ❒ Student _____ (School Name)

Who may we thank for your referral? _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Spouse/Responsible Party _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Social Security# _____ Birthdate _____ Driver's License # _____ State _____

Employer _____ Business Phone (____) _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Do you have medical insurance? _____ If yes, please provide us with your card for a photocopy to be made.

Relationship to the insured: ❒ Self ❒ Spouse ❒ Child ❒ Other _____

Insured's Name _____ Date of Birth _____ Social Security # _____

PAYMENT IS DUE AT TIME OF SERVICE. INSURANCE BILLING IS A COURTESY DONE BY THIS OFFICE FOR OUR PATIENTS, AND IN NO WAY RELIEVES YOU OF ANY FINANCIAL RESPONSIBILITY.

I authorize payment of my medical and/or surgical benefits to be made to Brentwood Dermatology. I understand that I am financially responsible for charges not covered by my insurance. I authorize Brentwood Dermatology to release any personal information and/or information regarding my examination and/or treatment that may be required by my insurance carrier, other MDs, HMOs or IPAs. In addition I acknowledge having received and read a copy of the HIPAA privacy practices.

Signed _____ Date _____

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize Jack H. Silvers, M.D. or his designee to treat my son or daughter, a minor child, in any manner deemed necessary to include examination, treatment and/or surgery if required. This authorization will remain in effect unless written notice terminating authorization is received by this office.

Signed _____ Date _____

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MEDICAL INFORMATION (FILL IN MEDICATIONS AND ALLERGIES)

I. Medical/Surgical History

Do you have now or have you ever had?

	YES	NO
High Blood Pressure	❒	❒
Diabetes/High Blood Pressure	❒	❒
Asthma	❒	❒
Tuberculosis	❒	❒
Thyroid Problems	❒	❒
Hayfever/Seasonal Allergies	❒	❒
Seizures	❒	❒
Stroke or Mini-Stroke	❒	❒
Heart Attack/Angina	❒	❒
Pacemaker	❒	❒
Heart Murmur/Palpitations	❒	❒
Kidney/Bladder Problems	❒	❒
Prostate Problems	❒	❒
Glaucoma	❒	❒
Hepatitis/Liver Disease	❒	❒
Recurrent Yeast Infections	❒	❒
Bowel Disease/Colitis/Crohn's	❒	❒
Frequent/ Severe Headaches	❒	❒
Cancer other than Skin	❒	❒
Radiation	❒	❒
Artificial Joint Heart Valve	❒	❒
Past Surgery	❒	❒
Other	❒	❒

If YES to any above, please explain:

_____

_____

_____

_____

II. Current Health:

	YES	NO
Do you smoke?	❒	❒
Do you drink alcohol?	❒	❒

How much? _____

III. Medications: (must be filled in)

List all medications you are taking, including any over-the-counter herbals or vitamins:

_____

_____

_____

IV. Dermatologic History:

Do you have now or have you ever had:

	YES	NO
Blistering Sunburns	❒	❒
Keloids/Abnormal Scarring	❒	❒
Skin Pigmentation Problems	❒	❒
Reaction to Local Anesthetic	❒	❒
Cold Sores/Herpes Infection	❒	❒
Eczema	❒	❒
Psoriasis	❒	❒
Abnormal ("Dysplastic") Moles	❒	❒
Precancerous Spots	❒	❒
Skin Cancer-Melanoma	❒	❒
Skin Cancer-Basal/Squamous Cell	❒	❒
Abnormal Cold Sensitivity	❒	❒
Abnormal Sun Sensitivity	❒	❒

If YES to any above, please explain:

_____

_____

_____

_____

V. Allergies: (must be filled in)

Are you sensitive/allergic to any medications?

Please list: _____

_____

VI. Family History:

Do you have a family history of:	YES	NO
Allergies/Asthma	❒	❒
Skin Cancer-Melanoma	❒	❒
Abnormal ("Dysplastic") moles	❒	❒
Skin Cancer-Basal/Squamous Cell	❒	❒
Other Skin Disorder	❒	❒

VII. Females:

	YES	NO
Excess Facial/Body hair	❒	❒
Regular Menstrual Periods when not on oral contraceptives	❒	❒

How many Pregnancies? _____

How many miscarriages/abortions? _____

Are you pregnant or nursing?	❒	❒

Ages of your children: _____

_____

_____

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