Marietta Dermatology & The Skin Cancer Center
and
Marietta Facial Plastic Surgery & Aesthetics Center

Today's Date _____ **Account #:** _____

Full Legal Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone# _____ **Cell#** _____

Email address _____ **Preferred Language**_____

Date of Birth _____ **Age** _____ **Sex** _____ **Race**_____**Ethnicity**_____

Soc Sec # (*REQUIRED* if filing ins) _____ **Marital Status** _____

Employer _____

Work Phone# _____ **Occupation** _____

Primary Insurance _____
Address _____
Primary ID # _____ **Group #** _____
Policy Holder _____**Relationship** _____
Policy Holder DOB _____**Policy Holder SS#** _____

Secondary Insurance _____
Address _____
Secondary ID # _____ **Group #** _____
Policy Holder _____**Relationship** _____
Policy Holder DOB _____**Policy Holder SS#** _____

Emergency Contact Name _____

Relationship to Patient _____ **Contact Phone#** _____

Personal Physician _____

Phone# _____ **Address** _____

Pharmacy Name _____ **Pharmacy #** _____

How did you hear about our office ?

_____

Authorization and Assignment of Benefits

I authorize **MDA and MFP,** to release medical information to my insurance companies about treatment and diagnoses necessary to process claims. I authorize assignment of benefits, including Medicare, to be paid on my behalf to MDA and MFP**,** for services rendered. I recognize that my insurance policy is a contract between my insurance company and me and that I am ultimately responsible for paying the claim should my insurance company deny payment.

If not covered by insurance, I understand that payment is expected at the time service is rendered, unless I made prior arrangements.

A photocopy of this shall be considered as valid as the original.

Patient Signature _____**Date**_____

(IF minor, parent or guardian signature)

Marietta Dermatology & The Skin Cancer Center
and
Marietta Facial Plastic Surgery & Aesthetics Center

MEDICAL QUESTIONNAIRE

Name _____ Age_____

Account # _____ Today's date _____

Reason for visit today_____

Do you have any problems with the following? Please indicate with an X all that apply.

Heart/Blood Pressure:	High Blood Pressure	_____	**Gastrointestinal:**	Ulcers	_____
	Low Blood Pressure	_____		Gastritis	_____
	Heart Attack	_____		Colitis/Diverticulitis	_____
	Heart Murmur	_____			
	Chest Pain/Tightness	_____	**Skin:**	Acne	_____
	Irregular Heartbeat	_____		Accutane	_____
	Leg Swelling	_____		Keloid Scarring	_____
				Rosacea	_____
				Cold Sores	_____
Lung:	Bronchitis/Pneumonia	_____			
	Asthma	_____	**Musculoskeletal/**	Convulsions	_____
	Shortness of Breath	_____	**Neurological:**	Epilepsy	_____
	Tuberculosis	_____		Headaches	_____
				Arthritis	_____
Ear, Eye, Nose	Dry Eyes	_____			
Or Throat:	Blurred Vision	_____	**Hematologic/**	Anemia	_____
	Glaucoma	_____	**Metabolic:**	Bleeding Problems	_____
	Corrective Lenses	_____		Blood Transfusion	_____
	Ear Disease	_____		HIV/AIDS	_____
	Nosebleeds	_____		Autoimmune Disease	_____
	Difficulty Breathing	_____		Diabetes	_____
	Nasal Allergies	_____		Thyroid Disease	_____
	Sinus Disease	_____		Hepatitis	_____

Have you ever been treated for Drug/Alcohol or Psychiatric/ Emotional problems such as Depression, Anxiety?
Yes No If yes, please explain _____

Have you ever had an anesthesia complication, latex allergy, or surgical tape allergy?
Yes No If yes, please explain _____

Have you used, within the past 5 years, the following substances? If you have quit, please indicate when.

Smoking Past Present If so, how often? _____
Alcohol Yes No How much per day? _____
Recreational Drugs Yes No What and How Often? _____
Do you take any Diet Medications? _____

Surgical History-Please list all previous surgeries (including Cosmetic)

Operation Surgeon Name Date

_____
_____
_____
_____

Hospitalizations (Other than for Surgery)

Illness Physician Name Date

_____
_____
_____

Medications, Vitamins and Herbs

Name of Drug/Vitamin Strength/Dosage Condition Treated

_____
_____
_____
_____

Drug Allergies (list any reactions to medications, tapes or antiseptic cleansers),
If no allergies, please mark ***NKDA*** (no known drug allergies)

_____
_____
_____

Height _____ Weight _____

If applicable, are you currently in pain? (0=Pain Free, 10= Most Severe Pain**)**

_____

Family History (Please indicate if any immediate family members has ever had any of the following)

Heart Disease _____
Bleeding Disorder _____
Diabetes _____
Anesthetic Complications _____
Cancer _____ What type of cancer? _____

Do you have any other medical problems that have not been covered? _____
_____

_____

_____ _____
Patient Signature Date

Reviewed by Physician (please initial) _____

MARIETTA FACIAL PLASTIC SURGERY
INTEREST QUESTIONNAIRE

Patient Name:	Date:
Account # :	

Areas of interest (please check all that apply).

❑ Skin care advice	❑ Facial veins	❑ Scar revision
❑ Skin care products	❑ Facial redness	❑ Sparse lashes
❑ Facial aging	❑ Thin lips	❑ Aging Hands
❑ Facial fine lines	❑ Prominent ears	❑ Other – please specify
❑ Facial wrinkles	❑ Drooping eyelids	_____
❑ Facial folds	❑ Nose	_____
❑ Dermal fillers	❑ Neck	Other services
❑ Botox ® Cosmetic	❑ Moles	❑ Hair Loss
❑ Blotchy skin	❑ Birthmarks	❑ Spider veins
❑ Brown spots/age spots	❑ Skin cancer	❑ Tattoo Removal

Please answer the following questions on a scale of 1 to 5. Please circle number

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

What is your skin care routine?