Skin and Laser Surgery Associates, a part of U.S. Dermatology Partners
Aaron K. Joseph, MD PA
Email: info@skinandlasermd.com

5125 Preston Ave., Ste. 150
Pasadena, TX 77505
Phone: (281) 991-0737
Fax: (281) 991-0738

PATIENT INFORMATION

LAST NAME:	FIRST NAME:		M. I.:
ADDRESS:	CITY:	STATE:	ZIP:
DATE OF BIRTH:	GENDER: ☐ Male ☐ Female	MARITAL STATUS: ☐ Single ☐ Married ☐ Widow ☐ Divorced	
HOME PHONE NUMBER:	CELL PHONE / OTHER PHONE NUMBER:	EMAIL ADDRESS:	

SOCIAL SECURITY NUMBER:	SPOUSE'S NAME:
DRIVER'S LICENSE NUMBER:	SPOUSE'S DATE OF BIRTH:
EMPLOYER:	SPOUSE'S EMPLOYER:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP	CITY: STATE: ZIP
WORK NUMBER – EXT:	WORK NUMBER – EXT:

REFERRING SOURCE

REFERRING PHYSICIAN:	TELEPHONE NUMBER:
PRIMARY CARE PHYSICIAN:	TELEPHONE NUMBER:

Do you have an Advance Directive / Power of Attorney / DNR orders filed with your Doctor's office?

☐ **YES, LOCATION:** ☐ **NO**

GUARANTOR / RESPONSIBLE PARTY

(IF DIFFERENT THAN PATIENT)

NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

EMERGENCY CONTACT / RELATIVE / FRIEND

LAST NAME: FIRST NAME: M.I.	RELATIONSHIP:	HOME PHONE:	
ADDRESS: CITY:	STATE: ZIP:	☐ WORK ☐ CELL PHONE:	

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY:	ADDRESS, CITY, STATE, ZIP:	TELEPHONE NUMBER:
POLICY NUMBER OR MEMBER NUMBER:	GROUP NUMBER:	
NAME OF POLICY HOLDER:	RELATIONSHIP (to policy holder): ☐ Self ☐ Spouse ☐ Child ☐ Other	
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	

NAME OF SECONDARY INSURANCE COMPANY:	ADDRESS, CITY, STATE, ZIP:	TELEPHONE NUMBER:
POLICY NUMBER OR MEMBER NUMBER:	GROUP NUMBER:	
NAME OF POLICY HOLDER:	RELATIONSHIP (to policy holder): ☐ Self ☐ Spouse ☐ Child ☐ Other	
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	

INSURANCE AUTHORIZATION AND ASSIGNMENT *(PLEASE READ AND SIGN)*

I HEREBY AUTHORIZE AARON JOSEPH, M.D., P.A., A PART OF U.S. DERMATOLOGY PARTNERS TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO AARON JOSEPH, M.D., P.A., A PART OF U.S. DERMATOLOGY PARTNERS, ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

SIGNATURE: **DATE:**

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NAME:_____ DATE OF BIRTH:_____

HISTORY AND INTAKE FORM – PLEASE COMPLETE IN FULL

PAST MEDICAL HISTORY: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension (high blood pressure)
HIV /AIDS
Hypercholesterolemia (high cholesterol)
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None
Other:_____

PAST SURGICAL HISTORY: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Implants
Colectomy: Colon Cancer, IBD, Diverticulitis
Gallbladder Removed
Coronary Artery Bypass
Heart Valve Replacement (mechanical / biological)
Heart Transplant
Pacemaker
Joint Replacement: Knee (Right, Left, Both)
Joint Replacement: Hip (Right, Left, Both)
Kidney Stone Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Liver Transplant
Ovaries Removed: Endometriosis, Cyst, Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicle Removed (Right, Left Both)
Hysterectomy: Fibroids, Cancer
None
Other:_____

SKIN DISEASE HISTORY: (please circle all that apply)

Acne
Actinic Keratosis
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma
None
Other:_____

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

Do you tan in a tanning salon? Yes No

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NAME:_____ DATE OF BIRTH:_____

FAMILY HISTORY: (Please circle all that apply and list which relative)

Melanoma? Yes No If yes, which relative(s)? _____

Other Skin Cancers (Basal Cell Carcinoma, Squamous Cell Carcinoma, etc.)? Yes No

If yes, which relative(s)? _____

MEDICATIONS: (Please provide ALL current medications) or circle NONE

_____

_____

_____

ALLERGIES: (Please enter all medication allergies)

_____

How long has current spot / spots been present? _____

What symptoms have you had? (circle) Itching Bleeding Pain Growing Color None

What treatment have you had other than biopsy? (circle) Excision Scraping Freezing Cream

SOCIAL HISTORY: (Please circle one in each category)

Cigarette / Cigar Smoking:
Never smoked
Quit: Former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
YES Social / Daily
NO

Language:
English
Spanish
Other:_____

Race:
White
Black /African American
Asian
American Indian or Native Alaskan

Ethnicity:
Hispanic / Latino
Non-Hispanic / Latino
Native Hawaiian / Pacific Islander

Place of Residence: (circle one) Home Nursing Home Assisted Living

Occupation:_____ **Retired:**_____

Primary Care Physician:_____ **Cardiologist:**_____

Pharmacy Name:_____ **Phone:**_____

Street:_____ **Zip Code:**_____