LEE AESTHETIC CENTER

PATIENT INTAKE QUESTIONNAIRE			
Title:		Referring Doctor Name:	
First Name:		Primary Care Provider Name:	
Middle Name:		Cardiologist (if any):	
Last Name:		Preferred Pharmacy	
Nick Name:		Pharmacy City:	
Home Phone:		Pharmacy Phone Number:	
Cell Phone:		**PRIMARY INSURANCE (SKIP IF COSMETIC)** (Leave blank if you have already given a copy of your insurance to the front desk)	
Work Phone:		Company Name	
Email		Insurance Card Number	
Contact Preference	☐ Home ☐ Cell ☐ Work ☐ Email	Policy holder Name	
Date of Birth		Relationship to policy holder	
Gender		Date of Birth (of subscriber)	
Race:	☐ White ☐ African American/Black ☐ Asian ☐ Other ☐ Decline	Referral needed?	☐ Yes ☐ No (most often HMOs will need referrals, please check your card)
Ethnicity:	☐ Hispanic ☐ Latino ☐ Not Hispanic or Latino ☐ Decline	**SECONDARY INSURANCE (SKIP IF COSMETIC)** (Leave blank if you have already given a copy of your insurance to the front desk)	
Preferred Language:	☐ English ☐ Spanish ☐ Other: _________________	Company Name	
Occupation:	☐ Employed ☐ Student ☐ Retired ☐ Other	Insurance Card Number	
Home Street Address:		Policy holder Name	
City:		Relationship to policy holder	
State:	Zip:	Date of Birth (of subscriber)	
Marital Status:	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other	Guarantor (if policy holder is not patient)	
Emergency Contact Name:		Emer. Contact Relationship:	
Emergency Contact Phone:		Medical information can be disclosed to the emergency contact listed here. **Initial here ______**	

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided and right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Communication Preferences

Okay to leave message with detailed information via ☐ **Cell Phone** ☐ **Home Phone** ☐ **Work Phone** ☐ **Email**

Okay to remind me of my appointments via ☐ **Cell Phone** ☐ **Home Phone** ☐ **Work Phone** ☐ **Email**

Okay to communicate with me via text message (message rates may apply) ☐ **Yes** ☐ **No**

Okay to e-mail a monthly newsletter with health tips, savings, and seasonal promotions ☐ **Yes** ☐ **No**

Okay to mail to my home address ☐ **Yes** ☐ **No**

Okay to send statements or financial information via email ☐ **Yes** ☐ **No**

List NAME AND ADDRESS OF **PHYSICIANS** AND/OR **INDIVIDUALS** (I.E. PHYSICIANS, FAMILY MEMBERS, NURSE, OR THYERAPIST) you wish a report or medical information disclosed to on your behalf.

NAME	ADDRESS

FINANCIAL AGREEMENT (FOR NON-COSMETIC PATIENTS)

Your insurance plan is a contract between you and your health insurance company. It is your responsibility to know your benefits and the limits of your coverage. We ask that payments, including any applicable deductible, co-payment, or co-insurance, be made at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, money orders, debit cards, and most credit cards.

Patients with HMO or POS Insurance

If you are a member of an HMO or POS plan, you need to have a valid referral from your primary medical doctor for each office visit and surgical procedure. Prior to your visit, please call in advance to ensure that all necessary forms and authorizations are in place. Without a valid referral, financial responsibility will lie upon the patient, and full payment will be due at the time of service.

You will be asked to sign this agreement upon your arrival to our office.

LEE AESTHETIC CENTER

GENERAL HEALTH HISTORY QUESTIONNAIRE PAGE 1

Patient Name: ______________________ **DOB:** ____________ **Today's Date:** __________

Please tell us about your CURRENT AND PAST health conditions by checking the boxes					
Please answer all questions	Y	N	Please answer all questions	Y	N
Cardiovascular			**Musculoskeletal**		
High blood pressure			Arthritis		
Taking medication for high blood pressure			Chronic back pain		
Coronary Artery Disease			Chronic neck pain		
Angina/chest pain			Fibromyalgia		
History of heart attack (MI)			Restless leg syndrome		
Congestive heart failure			Joint replacement, knee (R/L)		
Heart valve disease/murmur			Joint replacement, hip (R/L)		
Irregular heart rhythm			**Neurological/Psychological**		
Have pacemaker			Anxiety disorder		
Take aspirin daily			Bipolar disorder		
Take NSAIDs (ibuprofen/naproxen)			Dementia		
Take blood thinners			Depression		
Respiratory			History of stroke		
Asthma			Seizure disorder		
Emphysema/COPD			**Women only**		
Chronic bronchitis			Pregnant		
Recent respiratory infection			Breast-feeding		
Pneumonia			Hysterectomy		
Tuberculosis			**Other**		
Obstructive sleep apnea			Vasovagal response		
Use CPAP machine at night			Slow or poor wound healing		
Regular oxygen use			Cold sores, herpes, shingles		
Kidney/Bladder			Skin cancer/type		
Renal insufficiency			Other cancer, type		
Kidney failure requiring dialysis			Psoriasis, eczema, other skin disorder		
Incontinent of urine			MRSA, VRE, other infection		
Frequent infections			Hepatitis		
Endocrine/Rheumatologic			HIV or AIDS		
Diabetes controlled with insulin			Problems undergoing general anesthesia		
Diabetes controlled with oral meds			Problems undergoing conscious sedation		
Diabetes controlled with diet			Problems undergoing local anesthesia		
Lupus			Have you had two or more falls this year?		
Rheumatoid arthritis			Have you talked with your primary doctor about falls?		
Scleroderma			Has your doctor recommended weight loss?		
Thyroid disease			Are you working with your doctor on weight loss?		

GENERAL HEALTH HISTORY QUESTIONNAIRE	PAGE 2
Patient Name: ______________________________	

Please tell us about any OTHER current medical problems NOT LISTED PREVIOUSLY	
Medical Issue	Onset Date

Please tell us about any surgeries you have had		
Surgery site	Year of surgery	Surgeon or facility

Please tell us about cosmetic procedures (Botox, fillers, lasers, etc) you have had		
Procedure	Most Recent Treatment Date	Medical Provider

Please tell us about your social habits			
Smoking	Yes	No	Current amount (packs per day) and over how many years:
Former Smoker	Yes	No	Previous amount (packs per day) and over how many years:
Alcohol	Yes	No	Current amount (drinks per week):
Drug Use	Yes	No	Drug, frequency:
Marital Status (circle)	Single / Married / Divorced / Widowed		
Occupation			

Please tell us about your family's health history	
Father	
Mother	
Brother/Sister	
Brother/Sister	
Other:_____________	

LEE AESTHETIC CENTER

GENERAL HEALTH HISTORY QUESTIONNAIRE — PAGE 3

Patient Name: ____

List below all medications, supplements, vitamins, minerals and herbal supplements you take		
Medication name	Dose	Frequency (daily, twice daily, etc.)

Please tell us about your allergies or sensitivities to medications	
Allergy/Sensitivity	Reaction

Please tell us about your height, weight, and current pain by completing the table			
Height	____ft____in	Weight	___________ lbs
Pain (out of 10)	____/10	Location	

Please tell us about your immunizations by completing the table			
Have you had a pneumonia (pneumovax) vaccine?	Yes	No	If yes, when?
Have you had an influenza vaccine?	Yes	No	If yes, when?

GENERAL HEALTH HISTORY QUESTIONNAIRE — PAGE 4

Patient Name: ____

Please circle any of the following symptoms **if they are new**	
General	Weight gain (unintentional) / weight loss (unintentional) / loss of appetite / fever / diminished activity / fatigue
Ears/Nose/Throat	Pain / discharge / hearing loss / sinus pressure / drooling / facial swelling / congestion / sore throat / hoarseness / mouth lesions
Cardiovascular	Chest pain / rapid heart rate
Respiratory	Cough / wheezing / chest tightness / pain with breathing / rapid breathing / difficulty breathing / sleep apnea
Gastrointestinal	Difficulty swallowing / abdominal pain / nausea / vomiting / diarrhea / constipation / blood in stools / mucus in stool
Musculoskeletal	Soft tissue swelling / joint swelling / muscle pains / limited motion / trauma
Skin	Pain / itchiness / dry skin / flaking / redness / rash / diaper rash / hives / skin lesions / skin growths / skin lumps / bruising
Neurologic	Numbness / weakness / tingling / burning / shooting pain / headache / dizziness / loss of consciousness / seizures
Psychiatric	Depression / anxiety / insomnia / stress / loss of interest
Endocrine	Increased thirst / increased drinking / temperature intolerance / prominent eyes
Blood/hematologic	Easy bleeding / easy bruising / frequent nose bleeds
Eye	Pain / blurry vision / redness / itchiness / swelling / discharge / double vision

AUTHORIZATION TO USE SURESCRIPTS, INC.

1. I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: in accordance with New Jersey State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:
2. Lee Aesthetic Center, LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Lee Aesthetic Center, LLC.
3. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Lee Aesthetic Center, LLC.
4. I have the right to revoke this authorization at any time by writing to Lee Aesthetic Center, LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
5. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
6. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
7. This authorization expires one year from the date of my signature below.
8. THIS AUTHORIZATION DOES NOT AUTHORIZE LEE AESTHETIC CENTER, LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law: ______________________________

Date: ____________________ Relationship to patient: ______________________________