NEW PATIENT FORM

AESTHETIC DERMATOLOGY

Date: ______________________

PERSONAL INFORMATION

Name (Please Print)
LAST: ______________________ FIRST: ______________________ MIDDLE: ______________________
TITLE: ☐Ms. ☐Mrs. ☐Mr. ☐Dr. ☐Other: _________ NICKNAME: ______________________
GENDER: ☐Female ☐Male AGE_________ DATE OF BIRTH: _________/_________/_________
ETHNICITY: ______________________ WEIGHT: ______________
MARITAL STATUS: ______________________ SPOUSE'S NAME: ______________________

CONTACT INFORMATION

HOME: ______________________ or CELL: ______________________ *(Best number to reach)*
EMAIL: ______________________
ADDRESS: ______________________
CITY/ STATE/ ZIP: ______________________
PREFERRED CONTACT METHOD: ☐HOME ☐CELL ☐EMAIL
I ☐**WOULD** ☐**WOULD NOT** like to receive mail/email from Z Dermatology.
EMERGENCY CONTACT
LAST: ______________________ FIRST: ______________________
HOME/CELL: ______________________ OTHER: ______________________
RELATIONSHIP: ☐SPOUSE ☐PARENT/GUARDIAN ☐OTHER: ______________________
ADDRESS (Same as patient's? ☐YES ☐NO):
PREFERRED PHARMACY: ______________________

WHAT IS THE NATURE OF YOUR VISIT?

____
____

EMPLOYMENT INFORMATION

STATUS: ☐FULL-TIME ☐PART-TIME ☐RETIRED OTHER:______________________

OCCUPATION: ______________________ EMPLOYER: ______________________

REFERRAL INFORMATION

How did you hear about Z Aesthetic Dermatology? (Check all that apply)

☐ Friend/Family Member	☐Television	☐Facebook
☐ Patient	☐Magazine	☐Billboard
☐ Staff Member	☐Website	☐Other____________________

MEDICAL HISTORY

(*Female*) Are you pregnant? ☐YES ☐NO

Do you have children? ☐YES ☐NO If yes, how many? ___________________

Have you ever had any of the following conditions? (Check all that apply)

☐Asthma	☐Emphysema	☐High Blood Pressure	☐Diabetes / Insulin Dependent
☐Heart Trouble	☐Hepatitis	☐Liver Trouble	☐Autoimmune Disease
☐Problem Scarring	☐Stroke	☐Epilepsy/ Seizures	

Any other medical conditions not listed:

____

____

Have you ever had surgery? ☐YES ☐NO If yes, please describe:____

Have you ever had anesthesia complications? ☐YES ☐NO If yes, please describe:

____

Do you smoke? ☐YES ☐NO If yes, how much? ______________________________

Do you drink? ☐YES ☐NO If yes, how much? ______________________________

Please list any medications, vitamins or herbal supplements you are taking: ____________________________

____

Are you allergic to any medications or local anesthesia? ☐YES ☐NO If yes, please describe:

____

Z AESTHETIC DERMATOLOGY POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/ cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Appointment Deposit Policy: All appointments scheduled at Z Aesthetic Dermatology will require a 50% deposit at the time the appointment is being scheduled. ***All balances on procedures are due at the time of service.***

Cancellation of an Appointment: In order to be respectful of the medical needs of Z Aesthetic Dermatology patients and service providers please be courteous and call our offices promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment we require that you give 48-hour advance notice. ***Appointments are in high demand, and your early cancellation is appreciated.***

How to Cancel Your Appointment: To cancel appointments please call 225-778-7540 for Z Aesthetic Dermatology appointment desk. If you do not reach the receptionist you may leave a detailed message on the voice mail. If notice needs to be provided during non-office hours, please leave a detailed voicemail including your name, date of birth, phone number and a brief message. ***You may not cancel via email or text reminder response.***

Late Cancellations: Late cancellations will be considered a "No Show". ***"No Show" will forfeit their deposit for the appointment.***

Photo Use: Z Aesthetic Dermatology has the right to use before-and-after photos, provided that the patient's identity is neither disclosed nor apparent in the image(s). Initial: ________

Gift Cards and Credit on Accounts: All Gift cards and Credit on Accounts expire a year from date of purchase.

☐ I Have Read & Agree with the Z Aesthetic DermatologyPolicy

Patient Signature: ____ Date: ____________________