

◆ Please PRINT legibly & fill out ALL sections.

LAST NAME		FIRST NAME		MID. INITIAL	NICKNAME/PREFERRED NAME
MAILING ADDRESS			CITY	STATE	ZIP
RESIDENCE ADDRESS (if different from mailing)			CITY	STATE	ZIP
BIRTH DATE ____ / ____ / ____		SOCIAL SECURITY # ____ - ____ - ____		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
				MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
HOME PHONE:			CELL PHONE:		
WORK PHONE:			EMAIL: (for appointment reminders)		
PRIMARY CARE PHYSICIAN:					
Whom should we thank for referring you? <input type="checkbox"/> Maui News <input type="checkbox"/> Maui Bulletin <input type="checkbox"/> Google <input type="checkbox"/> Yahoo <input type="checkbox"/> Drive-by <input type="checkbox"/> Postcard Friend/Family _____ Doctor _____ Other _____					

◆ Insurance Information - Please present your INSURANCE CARD to staff.

I DO NOT HAVE INSURANCE and will pay all applicable fees. I am aware of the **consultation fee** and agree to remit that amount during my visit(s).

PRIMARY INSURANCE		Is this through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
SUBSCRIBER'S NAME	SUBSCRIBER'S BIRTH DATE	POLICY / ID NUMBER
SECONDARY INSURANCE (if applicable)		Is this through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No
SUBSCRIBER'S NAME	SUBSCRIBER'S BIRTH DATE	POLICY / ID NUMBER

◆ Employment Information

EMPLOYER			OCCUPATION		
ADDRESS		CITY	STATE	ZIP	PHONE

◆ If the client is a MINOR (under 18 years of age) please fill out this section.

MOTHER'S NAME		CELL PHONE	WORK PHONE
Does the client live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	ADDRESS (if different from client's address above)	CITY	STATE ZIP
FATHER'S NAME		CELL PHONE	WORK PHONE
Does the client live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	ADDRESS (if different from client's address above)	CITY	STATE ZIP

CONTINUED ON BACK →

EMERGENCY CONTACT NAME: _____	RELATIONSHIP: _____	PHONE: _____
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◆ Medical History

ALLERGIES <input type="checkbox"/> NONE _____ _____ _____	I AM ALLERGIC and/or SENSITIVE TO: <input type="checkbox"/> Tape/Adhesive <input type="checkbox"/> Band-Aids <input type="checkbox"/> Latex
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MEDICATIONS <input type="checkbox"/> NONE _____ _____ _____	_____ _____ _____
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DO YOU SMOKE/USE TOBACCO? <input type="checkbox"/> NO <input type="checkbox"/> QUIT smoking, when? _____ <input type="checkbox"/> YES → HOW MUCH a day? _____	_____
DO YOU CONSUME ALCOHOL? <input type="checkbox"/> NO <input type="checkbox"/> QUIT drinking, when? _____ <input type="checkbox"/> Light drinking <input type="checkbox"/> Heavy drinking <input type="checkbox"/> Socially	_____

FEMALE CLIENTS ONLY:	
Are you on oral contraceptives (birth control pills)? <input type="checkbox"/> NO <input type="checkbox"/> YES	Are you: <input type="checkbox"/> Pregnant <input type="checkbox"/> Trying to become pregnant <input type="checkbox"/> NEITHER

◆ Please check all MEDICAL CONDITIONS you have / had.

<input type="checkbox"/> NONE <input type="checkbox"/> Anxiety Disorder Type: _____ <input type="checkbox"/> Asthma <input type="checkbox"/> Basal Cell Cancer <input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Blistering Sunburns	<input type="checkbox"/> Cancer (non-skin) Type: _____ <input type="checkbox"/> Cataracts <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Eczema <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hayfever	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Hepatitis [Type: A / B / C] <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> Lupus <input type="checkbox"/> Melanoma <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Squamous Cell Cancer <input type="checkbox"/> Varicose Veins on Legs Other conditions not listed: _____ _____ _____
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◆ We offer a full range of COSMETIC SERVICES (not covered by insurance). Please indicate if you are interested in learning about these ANTI-AGING enhancements.

<input type="checkbox"/> RESTYLANE / RADIESSE / JUVEDERM / ARTEFILL / EVOLENCE for facial wrinkles, lines, sags, and hollow reduction <input type="checkbox"/> BOTOX for worry lines, forehead wrinkles, and crow's feet <input type="checkbox"/> CHEMICAL PEEL for smoother, even-toned skin <input type="checkbox"/> Lip enhancement	<input type="checkbox"/> ACNE solutions <input type="checkbox"/> BLOTCHY, ROUGH SKIN solutions <input type="checkbox"/> Broken blood vessels on face <input type="checkbox"/> Brown spots/blotchy skin. <input type="checkbox"/> Laser HAIR removal	<input type="checkbox"/> PHOTOFACIAL (IPL) for younger, tighter, smoother skin <input type="checkbox"/> MESOTHERAPY for body contouring <input type="checkbox"/> MOLE / SKIN TAG REMOVAL <input type="checkbox"/> Tattoo removal
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**Missed Appointments Policy: In order to provide quality service and availability to all of our patients, it is our policy to charge an office visit fee (\$80.00) for appointments not cancelled at least 24 hours in advance. Please call 877-6526 if you need to reschedule your appointment.*

I authorize this office to release to the named insurance company, including Medigap associated insurances (inclusive), and any information necessary to expedite insurance payment. I understand I am responsible for all charges regardless of insurance coverage. By signing this section, I assign payment of benefits provided by the group plan directly to Micki Ly, MD. I further agree that a photocopy/scanned document of the agreement shall be as valid as the original in the event of a dispute or a default. **I agree to pay all cosmetic consultation fees/copays/deductibles and reasonable collection charges, late fees, and/or attorney fees.** I agree to comply with the Office Policy Terms & Conditions which is available upon request and posted in the waiting room. All information provided is accurate to the best of my knowledge and I agree to all terms as above. I agree to update the office with name/address/insurance changes or incur admin. fees. I hereby acknowledge that I have read this information and have provided you my medical information to the best of my knowledge. I agree to all of the provisions contained herein. I agree to pay my estimated copay/consultation fee on the date of service, as well as applicable deductible and remaining copays and applicable late fees. I agree to the terms of the Office Policy & Conditions available upon request and posted in the waiting room.

SIGNATURE _____ <i>*(18 & over only)</i>	RELATIONSHIP <input type="checkbox"/> Client <input type="checkbox"/> Parent/Guardian
PRINT NAME _____	DATE _____ <input type="checkbox"/> Other _____