

**Micki Ly, MD**

**PLEASE PRINT**

**Today's date:** \_\_\_\_\_

General, Cosmetic and Surgical Dermatology

Rev 11/2007

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<b>Patient's Name:</b>	M	F	Birthdate	Home phone	Cell Phone	Work phone:
<b>Social Security #</b>						
Mailing address:			City	State	Zip Code	
<b>Residence Address:</b>						
Marital Status: (circle one) Single Married Divorced Widowed			Part time HI resident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Mainland Phone:	
Preferred Name:				E – Mail Address		
Name of Employer:		Employer's address:				
Occupation:		Employer's phone:				

**⇒IF THE PATIENT IS A MINOR (under 18 years of age)**

<b>Mother's name:</b>	Street address, City, State, Zip:			Home Phone:
Mother's Employer:	Occupation:	Work phone:	Does the Minor patient live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Father's name:</b>	Street address, City, State, Zip:			Home Phone
Father's employer:	Occupation:	Work phone:	Does the Minor patient live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
It patient is a <b>minor</b> (under 18 years old), who may authorize treatment?	Relationship to patient: Authorization Letter on file: <input type="checkbox"/> Yes <input type="checkbox"/> No			Phone:

**⇒PLEASE PRESENT INSURANCE CARD and Driver's License (identification/chart copy):**

Do you have Medical Insurance? (Please Present your Insurance card. We will make a copy) <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, how you intend to pay? <input type="checkbox"/> Check <input type="checkbox"/> cash <input type="checkbox"/> credit card (Please present Driver's License with Check payment) <input type="checkbox"/> V/MC # _____ CVV _____ Exp _____ (we will keep this on file for copayment)		
<b>Insurance Company name:</b> <b>Insurance Company's address:</b>	Is this through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Subscriber's name	<b>Subscriber's Birth Date:</b>	Policy number:	Group #:
Name of Spouse:		Birthdate of Spouse:	
Is there <b>Secondary Insurance</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Subscriber's Name / Insurance Company Name and address:		Subscriber's birthdate:
Person Financially responsible for this account: <input type="checkbox"/> Self <input type="checkbox"/> Other:		Address:	
<b>Emergency Contact Name:</b>		Relationship to Patient:	Phone:
Whom should we thank for referring you?			
Do you authorize release of your medical information to anyone Besides your Insurance Carrier?		If so, whom?	
<b>Do you have a phone answering machine at your house?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Prefer contact/messages via cell phone?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>May we leave message from this office on the machine:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No. <b>May we call you at work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			

I authorize this office to release to the named insurance company 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 fee/copays/deductible and reasonable collection charges, late fees, and /or attorney fees.** I agree to comply with the Office Policy Terms & Conditions which is avail. 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.

Patient, Parent or Guardian **Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

(NEXT PAGE--> TURN OVER to BACKSIDE--

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Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**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.

**MEDICAL HISTORY**

Whom may we thank you for referring to Dr. Ly:  Maui News  Maui Bulletin  Family  Friend \_\_\_\_\_  
 Primary care Physician (name) \_\_\_\_\_  Other: \_\_\_\_\_

**Allergies to Medication:** \_\_\_\_\_ **Current Medications:** \_\_\_\_\_  
**Other Known allergies:** \_\_\_\_\_

Surgeries & When \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you **smoke**?  No  Yes, How much a day and how long?  Quit Smoking already, when? \_\_\_\_\_  
Do you **drink**?  NO  Socially  Lite drinking  Moderate drinking  Heavy drinking  *Quit drinking* , when \_\_\_\_\_

History of **Drug Abuse**?  No  Yes please describe \_\_\_\_\_

Female patients only: Are you on Oral Contraceptives (Birth Control pills)  Yes  No  
Are you pregnant or trying to become pregnant?  Yes  No

**Check all medication conditions which you have or may have had:**

- Basal Cell cancer**  **Squamous cell cancer of the skin**  **Melanoma (depth \_\_\_\_\_)**
- Blistering sunburns
- Cancer (non-Skin) Type: \_\_\_\_\_ Date: \_\_\_\_\_ Treatment: \_\_\_\_\_
- Bleeding tendency  Diabetes  HIV  Heart Attack  Hypertension
- Stomach or duodenal ulcers  Hepatitis (type \_\_\_\_\_)  Mitral Valve prolapse
- Asthma  Eczema  Hayfever  Psoriasis  Lupus
- Cataracts  Glaucoma  Other condition (List) \_\_\_\_\_

**Family history of Skin disease or skin Cancer**  Yes, what type \_\_\_\_\_  No

Do you have an **artificial heart valve, joint, or other prosthesis** that requires you to take antibiotics when you have dental procedures:  Yes, what device: \_\_\_\_\_  No  
Antibiotics usually prescribed: \_\_\_\_\_

Are you allergic to **BandAids, tape or Adhesives**?  Yes  No

Please list any other Medical History we need to know: \_\_\_\_\_  
\_\_\_\_\_

We offer a full range of Cosmetic Procedures.

Please indicate if you are interested in learning about these anti-aging enhancements:

- Facial wrinkles/lines/ sags and hollow reduction (**Restylane Fillers/Radiesse/Juvederm/Artefill**)  Lip enhancement
- Worry lines/forehead wrinkles/ crows feet (**Botox**)  Skin tag, mole removal  **Acne solution**
- Brown spots, tattoo removal**  Blotchy / rough skin solution  Facial broken blood vessels/rosacea
- Photofacial for younger tighter and smoother skin/ laser skin rejuvenation  Chemical peel for smoother even toned skin
- Hair removal  Liposuction/body contouring

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 or applic late fees.** *I agree to the terms of the Office Policy & Conditions avail upon request and posted in the waiting room.*

**SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_