Micki Ly, MD

Aloha Dermatology & Laser Center
Leg Veins on Maui

rev 04/18/12
Acct #

♦ **Please PRINT legibly & fill out ALL applicable 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 mm / dd / yyyy	SOCIAL SECURITY #	**MARITAL STATUS** [ ] Single [ ] Married [ ] Divorced [ ] Widowed	**GENDER** [ ] MALE [ ] FEMALE

HOME PHONE:	CELL PHONE:
WORK PHONE:	EMAIL: (for appointment reminders)

PRIMARY CARE PHYSICIAN:

Whom should we thank for referring you? [ ] Maui News [ ] Maui Bulletin [ ] Google [ ] Yahoo [ ] Drive-by [ ] Postcard

Friend/Family_____ Doctor _____ Other _____

♦ **Insurance Information - Please present your INSURANCE CARD to staff.**

[ ] **I DO NOT HAVE INSURANCE, have out-of-network insurance (i.e. Kaiser, out of country), and/or electively choose not to use my medical insurance and will pay out-of-pocket.** I am aware of the ***consultation fee*** and agree to remit payment for all applicable fees during my visit(s).

PRIMARY INSURANCE		Is this through your employer? [ ] Yes [ ] No
SUBSCRIBER'S NAME	SUBSCRIBER'S BIRTH DATE	POLICY / ID NUMBER

SECONDARY INSURANCE (if applicable)		Is this through your employer? [ ] Yes [ ] 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/GUARDIAN NAME	CELL PHONE	WORK PHONE	Does the minor live with mother? [ ] Yes [ ] No
FATHER/GUARDIAN NAME	CELL PHONE	WORK PHONE	Does the minor live with father? [ ] Yes [ ] No

NAME OF SCHOOL

CONTINUED ON BACK →

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♦ Emergency Contact

NAME:	RELATIONSHIP:	PHONE:

♦ Medical History

ALLERGIES [_] NONE

I AM ALLERGIC and/or SENSITIVE TO:

_____ _____ [_] Tape/Adhesive [_] Band-Aids [_] Latex

_____ _____ _____ _____

MEDICATIONS [_] NONE

_____ _____ _____ _____

_____ _____ _____ _____

DO YOU SMOKE/USE TOBACCO? [_] NO [_] QUIT [_] YES → [_] Rarely [_] 1-3/day [_] 4-6/day [_] 8-10/day [_] 10+/day

DO YOU CONSUME ALCOHOL? [_] NO [_] QUIT [_] YES → [_] Socially [_] 1-3/day [_] 4-6/day [_] 8-10/day [_] 10+/day

FEMALE CLIENTS ONLY fill out this section.

Are you on oral contraceptives (birth control pills)? [_] NO [_] YES **Are you pregnant?** [_] NO [_] YES

♦ Please check all MEDICAL CONDITIONS you have / had.

[_] NONE

- [_] Anxiety Disorder
  Type: _____
- [_] Asthma
- [_] Basal Cell Cancer
- [_] Bleeding Tendency
- [_] Blistering Sunburns
- [_] Cancer (non-skin)
  Type: _____
- [_] Cataracts
- [_] Diabetes
- [_] Drug Abuse
- [_] Eczema
- [_] Glaucoma
- [_] Hayfever
- [_] Heart Attack
- [_] Hepatitis [Type: A / B / C]
- [_] High Blood Pressure
- [_] High Cholesterol
- [_] HIV
- [_] Lupus
- [_] Melanoma
- [_] Mitral Valve Prolapse
- [_] Psoriasis
- [_] Squamous Cell Cancer
- [_] Varicose Veins on Legs

Others not listed:

_____

_____

_____

♦ 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.

- [_] RESTYLANE / RADIESSE / JUVEDERM / ARTEFILL / EVOLENCE for facial wrinkles, lines, sags, and hollow reduction
- [_] BOTOX for worry lines, forehead wrinkles, and crow's feet
- [_] CHEMICAL PEEL for smoother, even-toned skin
- [_] Lip enhancement
- [_] ACNE solutions
- [_] BLOTCHY, ROUGH SKIN solutions
- [_] Broken blood vessels on face
- [_] Brown spots/blotchy skin.
- [_] Laser HAIR removal
- [_] PHOTOFACIAL (IPL) for younger, tighter, smoother skin
- [_] MESOTHERAPY for body contouring
- [_] MOLE / SKIN TAG REMOVAL
- [_] Tattoo removal

**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 _____ **RELATIONSHIP** [_] Client [_] Parent/Guardian
**(18 & over only)*

PRINT NAME _____ **DATE** _____ [_] Other _____