Micki Ly, MD
Aloha Dermatology & Laser Center
Leg Veins on Maui

rev 07/31/12
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	SOCIAL SECURITY #	**GENDER**	**MARITAL STATUS**
___ ___ / ___ ___ / ___ ___ ___ ___		[_] Male [_] Female	[_] Single [_] Married [_] Divorced [_] Widowed

HOME PHONE [_] preferred phone for message(s)	CELL PHONE [_] preferred phone for message(s)
WORK PHONE [_] preferred phone for message(s)	EMAIL (for appointment reminders)
PRIMARY CARE PHYSICIAN	**PREFERRED LANGUAGE** (other than English)

RACE (select ONE)
[_] Asian
[_] Hispanic/Latino
[_] White/Caucasian
[_] Black/African American
[_] Native American/Alaska Native
[_] Pacific Islander/Native Hawaiian

ETHNICITY (select ONE)
[_] African American
[_] Alaska Native
[_] Caucasian
[_] Chinese
[_] Filipino
[_] Hawaiian
[_] Japanese
[_] Korean
[_] Mexican
[_] Micronesian
[_] Portuguese
[_] Samoan
[_] Spanish
[_] Tongan
[_] Vietnamese
[_] Other

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			

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♦ Emergency Contact

NAME	RELATIONSHIP	PHONE

♦ Medical History

DRUG ALLERGIES **[_] NONE**

_____________________ _____________________ _____________________ **I AM ALLERGIC and/or SENSITIVE TO:**

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

CURRENT MEDICATIONS **[_] NONE**

_____________________ _____________________ _____________________ _____________________

_____________________ _____________________ _____________________ _____________________

DO YOU SMOKE/USE TOBACCO? [_] NO [_] FORMER SMOKER [_] DAILY SMOKER [_] OCASSIONAL/SOCIAL SMOKER

DO YOU CONSUME ALCOHOL? [_] NO [_] FORMER DRINKER [_] DAILY DRINKER [_] OCASSIONAL/SOCIAL DRINKER

♦ 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, I assign payment of benefits provided by the group plan directly to Micki Ly, MD. Under medical privacy protection, I understand that my information is private and thus I agree to the HIPAA policy (Health Insurance Portability and Accountability Act). I further agree that a photocopy/scanned document of this 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 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. I agree to update the office with name/address/insurance changes. I hereby acknowledge that I have read this information and provided my medical information to the best of my knowledge. I agree to all of the provisions contained herein.

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

PRINT NAME ____ **DATE** __________ [_] Other ______________