

**Please print.**

<b>Last Name:</b>		<b>First Name:</b>		Preferred Name:	
<b>Mailing Address:</b>		City	State	Zip Code	
<b>Residence Address:</b>		City	State	Zip Code	
Part time HI resident? (circle one)    Yes    No		If yes, what state?		Mainland Phone:	
Birth Date:	Social Security #	<input type="checkbox"/> Male	<b>Marital Status:</b> (circle one)		
		<input type="checkbox"/> Female	Single   Married   Divorced   Widowed		
Home Phone:	Cell Phone:	<b>E-mail</b> (for appointment reminders and promotions):			
Work Phone:	<b>Occupation:</b>	Employer:			
Whom should we thank for referring you? <input type="checkbox"/> Maui News <input type="checkbox"/> Maui Bulletin <input type="checkbox"/> Family Magazine <input type="checkbox"/> Google <input type="checkbox"/> Yahoo <input type="checkbox"/> Drive-by					
Friend _____ Family _____ Doctor: _____ Other _____					
<b>Name of Primary Care Physician:</b>					
<b>Emergency Contact Name:</b>		Relationship:		Phone:	

\*\*\* Please present insurance card to staff \*\*\*

Do you have <u>Medical Insurance</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Primary Insurance:</b>		Is this through your employer? (circle one)    Yes    No
Subscriber's Name:	Subscriber's Birth Date:	Policy/ID Number:
<b>Secondary Insurance</b> (if applicable):		
Subscriber's Name:	Subscriber's Birth Date:	Policy/ID Number:
Person <i>financially responsible</i> for this account: <input type="checkbox"/> Self <input type="checkbox"/> Other _____	Street Address, City, State, Zip:	

\*\*\* If the client is a **minor (under 18 years of age)** → Who is the responsible person: \_\_\_\_\_

<b>Mother's name:</b>	Street Address, City, State, Zip:	Home Phone:
Mother's Occupation / Employer:	Work phone:	Does the 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 Occupation / Employer:	Work phone:	Does the patient live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Who may authorize treatment? Do you have an <b>answering machine</b> at home? <input type="checkbox"/> Yes <input type="checkbox"/> No      Prefer contact/messages via <b>cell phone</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave message(s) from this office on the <b>machine</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No.      May we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		

I authorize this office to release to the named insurance company, including Medigap associated insurances (inclusive), 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 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.



**Signature** (Over age 18 only): **X** \_\_\_\_\_ (please check)  Client    Parent/Guardian

Print Name: \_\_\_\_\_

Name: \_\_\_\_\_

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**

<p><b>Surgeries &amp; when:</b> _____                  _____                  _____                  _____</p>	<p><b>Medications:</b> _____                  _____                  _____                  _____</p>
<p><b>Allergies:</b>                  _____                  _____                  _____</p>	<p>If you have an artificial heart valve, joint, or other prosthesis that requires you to take antibiotics when you have dental procedures, please list what device / antibiotics usually prescribed: _____                  _____</p>
<p>Are you allergic to: (circle all that apply)                  Tape    BandAids    Adhesives    None</p>	<p><b>Female patients only:</b>                  Are you on oral contraceptives (birth control pills)?    <input type="checkbox"/> No    <input type="checkbox"/> Yes                  Are you pregnant or trying to become pregnant?    <input type="checkbox"/> No    <input type="checkbox"/> Yes</p>
<p>Do you smoke?  <input type="checkbox"/> No.    Quit smoking, when? _____  <input type="checkbox"/> Yes - How long / how much a day? _____</p>	<p>Do you drink?  <input type="checkbox"/> No.    Quit drinking, when? _____  <input type="checkbox"/> Yes - Socially    Light drinking    Heavy drinking</p>
<p>History of drug abuse? If so, please describe. _____                  _____</p>	

\*\*\* Circle medical problems that you have/had \*\*\*

Asthma	Blistering Sunburns	Bleeding Tendency	Cataracts
Diabetes	Eczema	Glaucoma	Hayfever
Heart Attack	HIV	<b>Basal Cell Cancer</b>	<b>Squamous Cell Cancer</b>
Hypertension	Lupus	Hepatitis ( Type: A / B / C )	<b>Melanoma</b> (Depth ____)
Mitral Valve Prolapse	Psoriasis	Cancer (non-skin) Type: _____ Date: _____	
Other:		Treatment: _____	
Any other medical history not listed: _____ _____			

**We offer a full range of cosmetic procedures. Please indicate if you are interested in learning about these anti-aging enhancements.**

- |   |   |
|---|---|
| <input type="checkbox"/> Facial wrinkles, lines, sags, and hollow reduction (Restylane Fillers / Radiesse / Juvederm / Artefill / Evolence) | <input type="checkbox"/> Photofacial (IPL) for younger, tighter, and smoother skin,                 |
| <input type="checkbox"/> Worry lines, forehead wrinkles, crows feet (Botox)   | <input type="checkbox"/> Laser for skin tightening  |
| <input type="checkbox"/> Lip enhancement  | <input type="checkbox"/> Chemical peel for smoother even toned skin                                 |
| <input type="checkbox"/> Hair removal   | <input type="checkbox"/> Liposuction, body contouring   |
| <input type="checkbox"/> <b>Acne solution</b>   | <input type="checkbox"/> Facial broken blood vessels <input type="checkbox"/> <b>Varicose veins</b> |
| <input type="checkbox"/> Tattoo removal   | <input type="checkbox"/> Brown spots <input type="checkbox"/> <b>Spider veins</b>                   |
| <input type="checkbox"/> Skin tag, mole removal   |   |
| <input type="checkbox"/> Blotchy rough skin solution  |   |

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 (Over age 18 only):** **X** \_\_\_\_\_ (please check)  Client  Parent/Guardian

Print Name: \_\_\_\_\_