Déjà Vu
SKIN & HEALTH CENTER

Clovis Manley, MD
4943 Rosebud Lane
Newburgh, IN 47630
(812) 490-SKIN (8346)

Medical History and Skin Care Questionnaire

Name _____ Date of Birth _____ Sex _____ Date _____ Age_____

How did you first hear of us? (check all that apply):

□TV □Radio □ Internet Search □ Website □ Physician _____
□ Family/Friend □ Newspaper □ Social Media _____ □ Other_____

Who can we thank for referring you to us? _____

If you would like to be added to our email blast to learn about specials, promotions etc., please list your email address: _____

Medical History

Medical Conditions: (check any condition that applies to you or list them below):

□ Diabetes □ Cancer- Type_____ □ Hypertension □ Neurological disease
□ Thyroid □ Bleeding disorder □ Lupus □ Myasthenia gravis
□ Hernia □ Rheumatoid Arthritis □ Raynaud's □ Migraine headaches

- _____
- _____
- _____
- _____

- _____
- _____
- _____
- _____

Surgical History (please list past surgeries, non-cosmetic)

- _____
- _____
- _____

- _____
- _____
- _____

Current Medications: (list all prescriptions, over the counter, herbal, vitamins, & supplements)

- _____
- _____
- _____
- _____

- _____
- _____
- _____
- _____

Medication Allergies _____ □ None

Other Allergies/Sensitivities (check all that apply):

□ Aspirin □ Metal □ Latex □ Caines (lidocaine, benzocaine)

Health Risk Assessment

Use of tobacco: □ Cigarettes Age started_____ Packs/amount per day: _____
□ Never used it □ Cigars Age Stopped _____
□ Used to but quit □ Pipe
□ Still use it □ Snuff/chew

What describes your use of alcoholic beverages? (may choose more than one)

□ Never a drinker □ 1-2 drinks weekly □ Drink heavy on weekends only □ I need help
□ 1-5 drinks per year □ 1-2 drinks daily □ Heavy drinker all week □ Former drinker
□ 1-2 drinks per month □ 3 or more drinks daily □ One/both of my parents are alcoholics

Women Only (check all that apply):

□ Hysterectomy □ Tubal ligation □ I could be pregnant □ Post-menopause
□ Pregnant : Due date ____/____/____ □ Nursing until: ____/____/____
First day of your last menstrual period ____/____/____ Type of birth control used _____

Skin Care Questionnaire

Skin History (check all that apply)

□ Precancerous skin lesion □ Keloids □ Herpes, cold sores □ Eczema
□ Recurrent Skin Rash □ Acne □ Ulcers □ Psoriasis
□ Skin cancer (if so circle all that apply) Squamous, Basal cell, Melanoma □ Sun Poisoning

Have you ever taken Accutane? □ No □ Yes When was your last dose ____/____/____

When in the sun for one hour without protection do you (circle one).....I Always burn and never tan
II Always burn and sometimes tan
III Sometimes burn and sometimes tan
IV Never burn and always tan
V Asian, Mediterranean, Hispanic
VI African American

Present Skin Conditions (check all that apply)

□ Brown Spots or Age Spots □ Skin Pigmentation Problems □ Whiteheads or Blackheads
□ Facial Redness □ Broken Facial Capillaries □ Fine Lines & Wrinkles
□ Oily Skin □ Clogged Pores □ Leg Spider Veins or Varicose Veins
□ Dry, Flaky Skin □ Moles you would like removed □ Crusty or Scaly areas that never heal
□ Unwanted Tattoos □ Melasma □ Moles that have changed shape or color
□ Acne Scarring □ Enlarged Pores □ Rosacea
□ Uneven Texture □ Lax or Sagging Skin □ Dark Under-Eye Circles

□ Excessive Sweating (if so circle all that apply) Hands, Feet, Scalp, Underarms

Do you currently see a dermatologist? □ No □ Yes (Why?) _____
Do you bruise easily? □ No □ Yes
What type of skin do you think you have? □ Dry □ Normal □ Combination □ Oily
Have you ever had a reaction to any skin care product? □ No □ Yes (what?) _____

What skin care products do you use during your daily routine? (include soaps, moisturizers, oils, etc)

Morning	Evening
1) _____	1) _____
2) _____	2) _____
3) _____	3) _____
4) _____	4) _____
5) _____	5) _____

Are you happy with your current skin care products? □ No □ Yes

Cosmetic History (please list dates when applicable)	Yes	No	Date
Facial Plastic Surgery	□	□	____/____/____
Other Cosmetic Surgery (please list) _____	□	□	____/____/____
Dermal Filler Injections (what product?)_____	□	□	____/____/____
Botox® or Other Toxins (what toxin?) _____	□	□	____/____/____
Chemical Peels	□	□	____/____/____
Dermaplane or Microdermabrasion	□	□	____/____/____
Skin Resurfacing (CO2, Microlaserpeel, etc)	□	□	____/____/____
Photorejuvenation (BBL and/or IPL)	□	□	____/____/____
Laser Treatment of Veins	□	□	____/____/____
Sclerotherapy (injection) of veins	□	□	____/____/____
Coolsculpting	□	□	____/____/____

Which of the the following areas are you interested in making improvements? (check all that apply)

□ Eyelashes	□ Lips	□ Nose	□ Neck	□ Double chin
□ Chest	□ Arms	□ Hands	□ Abdomen	□ Thighs inner/outer
□ Feet	□ Cellulite	□ Face	□ Legs	

Hair Removal

Do you have unwanted hair on your body? □ No □ Yes (Where?) _____

	Yes	No	Date
Have you had hair removal by electrolysis?	□	□	_____
Laser (IPL, BBL, etc.)	□	□	_____
Waxing?	□	□	_____
Threading	□	□	_____
Other Means?	□	□	_____

Do you use tanning beds? □ No □ Yes ..... If yes, when was the last session? ____/____/____

Do you use self tanners or spray tan? □ No □ Yes ..... If yes, when was last use? ____/____/____

When were you last exposed to the sun (tanning or working/playing outside)?..... ____/____/____

Do you have a vacation or sun exposure planned? □ No □ Yes ..... If yes, when? ____/____/____

Do you have an upcoming event that you are planning for? □ No □ Yes ... If yes, when? ____/____/____

GOALS AND EXPECTATIONS

If there was something you could change or improve about your skin, what would it be?

_____

_____

_____

_____

Is there anything else you would like us to know before we start your treatment plan?

_____

_____

_____

_____

CLOVIS E MANLEY, MD LLC
4943 Rosebud Lane
Newburgh, IN 47630

PATIENT DEMOGRAPHIC FORM

Please present your driver's license or other photo ID, most recent insurance card(s) and copay if applicable.

Please PRINT

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **MI:**_____

Date of Birth:_____ **Social Security Number:**_____ **Gender:** ☐ Male ☐ Female

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Cell Phone #:(____)_____ **Home Phone #:**(____)_____ **Email Address:**_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Self Employed ☐ Not Employed ☐ Disabled ☐ Retired ☐ Active Duty Military

Employer Name: _____ **Phone #:**(____)_____ **Occupation:** _____

EMERGENCY CONTACT

Name:_____ **Phone #:**(____)_____ **Relationship to Patient:**_____

PRIMARY INSURANCE

Insurance Name:_____ **Policy/ID #:**_____ **Effective Date:**_____

Policy Holder's Relationship to Patient: ☐ Self (DO NOT complete shaded section below) ☐ Spouse ☐ Parent ☐ Other (specify):_____

Name of Policy Holder:_____ **DOB:**_____ **SSN #:**_____

Address (if different than the patient):_____ Phone #:(____)_____

SECONDARY INSURANCE (if applicable)

Insurance Name:_____ **Policy/ID #:**_____ **Effective Date:**_____

Policy Holder's Relationship to Patient: ☐ Self (DO NOT complete shaded section below) ☐ Spouse ☐ Parent ☐ Other (specify):_____

Name of Policy Holder:_____ **DOB:**_____ **SSN #:**_____

Address (if different than the patient):_____ Phone #:(____)_____

I certify the above information is correct to the best of my knowledge.

Signature:_____ **Date:** _____

Verified Date/Initials ____/____ ____/____ ____/____ ____/____ ____/____ ____/____ ____/____
____/____ ____/____ ____/____ ____/____ ____/____ ____/____ ____/____

Clovis E. Manley, MD, LLC
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Patient's Name_____ **DOB** _____ **Date** _____

AUTHORIZATIONS, ASSIGNMENT OF BENEFITS, FEES AND PRIVACY NOTICE

1. Treatment authorization. I expressly authorize this practice to provide me with reasonable and proper care by the standard of care in the community.

2. Medicare lifetime signature on file (applies to Medicare patients only). I request payment of authorized Medicare benefits be made to Clovis E. Manley, MD, LLC for any services furnished to me by this practice. I authorize any holder of medical information about me to release required information to the Center for Medicare and Medicaid Services (CMS) and its agents as needed to determine benefits and payment for benefits for services rendered. Our office accepts assignment on fees for our Medicare patients. We will submit your Medicare claims to CMS for you.

3. Assignment of benefits. I request payment of authorized medical insurance benefits be made on my behalf to Clovis E. Manley, MD, LLC. I understand that the office does not accept all forms of insurance. I understand the office will file my insurance claim to accepted insurance plans as a courtesy to me. I am responsible for payment of co-pays, coinsurance, and deductibles for covered services. Services that are not covered by insurance are my responsibility and I agree to pay in full. I authorize the release of my medical information needed to process my insurance claims.

4. Non-acceptance of Medicaid. I understand that Clovis E. Manley, MD LLC and its business entities do not accept Medicaid benefits or Medicaid-funded insurance plans. I understand that my medical claims will not be filed to Medicaid for processing.

5. Insurance cards. I agree to inform the office of any changes in my insurance coverage in advance of obtaining any additional services. I will bring my insurance card to every visit.

6. Contact information. I agree to inform the office of any changes in my contact information, including name, phone number, and mailing address.

7. Record copying fee. I understand I have a right to the information in my medical records, but the original records belong to my provider. I understand it is expensive and time consuming to copy medical records. I understand that a reasonable copying fee will be charged anytime I request a copy of my records or transfer my records to another provider. However, **I will not be charged** for: (1) copies of recent lab/imaging tests, (2) records sent to a specialist that the office refers me to, or (3) a copy of my most recent office visit.

8. Missed appointment fee. I understand my credit card will be placed on file to hold my appointment or procedure time. **My credit card will not be charged unless**: I no show or fail to cancel or reschedule within 24 hours. A missed appointment fee is $50.00. A missed procedure fee is $100.00.

9. Collection fees. I agree that if any unpaid balance is assigned to a third-party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay any attorney fees or court costs incurred in the course of the collection of my fees. I agree to pay pre-judgment and/or post judgment interest on any overdue balance at the current legal rate.

10. Privacy policy. I received a copy of the Notice of Privacy Practices for Clovis E. Manley, MD, LLC.

Signature _____