Brentwood
Dermatology

SOME OF OUR SERVICES

- Thicker Hair Using Your Own Molecules
- Skin Cancer Screening and Treatment
- Mole Removal with Minimal or No Scar
- Facial Redness & Leg Spider Veins
- Relieving Stress Incontinence Using PRP
- Vampire Face, Neck, Breast & Tummy Lift
- Natural Appearing Lip & Facial Fullness Restoration
- Rejuvination and Lifting of Eyelids and Dark Circles
- Botox, Dysport, & Sugar-Based Fillers
- Microneedling to Shrink Pores and Tighten Skin
- P-Shot, O-Shot & Lichen Sclerosus
- Rhino Boost for Genital Rejuvenation

PATIENT INFORMATION

Today's Date____ Birthdate____ Age____ ❒ Male ❒ Female

Patient's Name____ Cell Phone (___)____ E-mail ____

Address____ City____ State____ Zip____

Social Security#____ Driver's License #____ State____

In Emergency - Contact Name & Phone Number____ Marital Status ☐S ☐M ☐D ☐W ❒

Patient's Employer ____ Business Phone (___)____ Home Phone (___)____

Address____ City____ State____ Zip____

Occupation____ How Long Employed ____ Student____ (School Name)

Who may we thank for your referral? ____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Spouse/Responsible Party____ Home Phone (___)____

Address____ City____ State____ Zip____

Social Security#____ Birthdate____ Driver's License #____ State____

Employer ____ Business Phone (___)____

INSURANCE INFORMATION

Do you have medical insurance?____ If yes, please provide us with your card for a photocopy to be made.

Relationship to the insured: ❒ Self ❒ Spouse ❒ Child ❒ Other____

Insured's Name ____ Date of Birth ____ Social Security #____

PAYMENT IS DUE AT THE TIME OF SERVICE. INSURANCE BILLING IS A COURTESY DONE BY THIS OFFICE FOR OUR PATIENTS AND IN NO WAY RELIEVES YOU OF ANY FINANCIAL RESPONSIBILITY.

I authorize payment of my medical and/or surgical benefits to be made to Brentwood Dermatology. I understand that I am financially responsible for charges not covered by my insurance. I authorize Brentwood Dermatology to release any personal information and/ or information regarding my examination and/or treatment that may be required by my insurance carrier, other MDs, HMOs or IPAs. In addition, I acknowledge having received and read a copy of the HIPAA privacy practices.

Signed____ Date ____

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize Jack H. Silvers, M.D. or his designee to treat my son or daughter, a minor child, in any manner deemed necessary to include examination, treatment and/or surgery if required. This authorization will remain in effect unless written notice terminating authorization is received by this office.

Signed____ Date ____

Continued on back

MEDICAL INFORMATION (FILL IN MEDICATIONS AND ALLERGIES)

I. Medical/Surgical History

Do you now have, or have you ever had?

	YES	NO
High Blood Pressure	○	○
Diabetes	○	○
Asthma	○	○
Tuberculosis	○	○
Thyroid Problems	○	○
Hayfever/Seasonal Allergies	○	○
Seizures	○	○
Stroke or Mini-Stroke	○	○
Heart Attack/Angina	○	○
Pacemaker	○	○
Heart Murmur/Palpitations	○	○
Kidney/Bladder Problems	○	○
Prostate Problems	○	○
Glaucoma	○	○
Hepatitis/Liver Disease	○	○
Recurrent Yeast Infections	○	○
Bowel Disease/Colitis/Crohn's	○	○
Frequent/Severe Headaches	○	○
Cancer other than Skin	○	○
Radiation	○	○
Artificial Joint Heart Valve	○	○
Past Surgery	○	○
Other	○	○

If YES to any above, please explain:

_____

_____

_____

_____

II. Current Health

	YES	NO
Do you sleep 8 hours uninterruptedly nightly?	○	○
Do you smoke?	○	○
Do you drink alcohol?	○	○

How much? _____

III. Medications: (must be filled in)

List all the medications and supplements that you are taking, including any over-the-counter pills, herbals, vitamins, and aspirin:

_____

_____

_____

IV. Dermatologic History

Do you have, or have you had?

	YES	NO
Blistering Sunburns	○	○
Keloids/Abnormal Scarring	○	○
Skin Pigmentation Problems	○	○
Reaction to Local Anesthetic	○	○
Cold Sores/Herpes Infection	○	○
Eczema	○	○
Psoriasis	○	○
Abnormal ("Dysplastic") Moles	○	○
Precancerous Spots	○	○
Skin Cancer-Melanoma	○	○
Skin Cancer-Basal/Squamous Cell	○	○
Abnormal Cold Sensitivity	○	○
Abnormal Sun Sensitivity	○	○

If YES to any above, please explain:

_____

_____

_____

_____

V. Allergies: (must be filled in)

Are you sensitive/allergic to any medications?

Please list:

_____

_____

VI. Family History:

Do you have a family history of:	YES	NO
Allergies/Asthma	○	○
Skin Cancer-Melanoma	○	○
Abnormal ("Dysplastic") moles	○	○
Skin Cancer-Basal/Squamous Cell	○	○
Other Skin Disorder	○	○

VII. Females:

	YES	NO
Excess Facial/Body Hair	○	○
Regular Menstrual Periods when not on oral contraceptives	○	○

How many Pregnancies? _____

How many miscarriages/abortions? _____

Are you pregnant or nursing?	○	○

Ages of your children:

_____

_____

_____

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