Daniels Vein & Cosmetic Center Richard J. Daniels, M.D. PA
9500 K. Johnson Blvd, Suite 3,
Bordentown, NJ 08505
Tele: 609-298-0033 Fax: 609-298-0043
Website: www.danielsveincenter.com

PATIENT REGISTRATION FORM

Accurate patient information is an important part of quality medical care. We ask that you take a few minutes and complete the following information to update your medical records.

How did you hear about our practice? _____

Patient Name: _____ DOB: _____

Address: _____

Cell Phone: _____ Email Address: _____
Age: _____ □ Female □ Male Marital Status S / M / W / D

Employment: _____
Occupation:: _____

Emergency Contact: Name: _____ Phone: _____
Relationship to Patient: _____

Are you pregnant: Yes No If yes, how far along: _____

Are currently in the care of a Dermatologist or other Physician? Yes No

If yes, please specify for what reason and when? _____
_____

Have you ever been hospitalized before? Yes No

If yes, please specify for what reason and when? _____

Have you ever had any significant Surgery? Yes No

If yes, please explain along with dates? _____

Please list ALL Allergies to food or skin care products: _____
_____

Please list ALL medications/Nutritional Supplements you are currently taking (please include dose and how often):
_____
_____

Do you have any of the following health conditions:

AIDS/HIV Cancer Diabetes Heart Problems Hepatitis High/Low Blood Pressure Lupus

Please list any other health conditions not listed above:
_____

Are you currently using any of the following?

Retin A/Renova Glycolic Acid/Alpha Hydroxy Acid Accutane Topical Vitamin C Hydroquinone
Hormone Replacement Therapy Birth Control Pills Sunscreen/Sun Bloc

Tobacco Use: Yes No How much? _____--_____ Alcohol Use: Yes No How Much? _____

Do you suffer from Cold Sores? Yes No

If yes, do you take medication? Yes No What brings on an outbreak?_____

Do you use a tanning bed? Yes No If yes, last session was on? _____

Have you had any of the following?

Cosmetic Surgery Botox Facial Injections Skin Cancer Dermatitis Keloid Scarring

Laser Resurfacing Chemical Peels Other _____

If yes to any of the above, please state when your last treatment was: _____

What areas of concern do you have regarding your skin?

Breakouts/Acne Blackheads/Whiteheads Excessive Oil/Shine Rosacea Broken Capillaries
Sun/Liver/Brown Spots Enlarged Pores Uneven Skin Tone Sun Damage Wrinkles/Fine Lines
Dull/Dry Skin/Flaky Skin Dehydrated

Other _____

What are your 3 primary concerns: _____

Is there any other information I should know before beginning your treatment?

_____

It is your responsibility to inform your Skin Care Provider of any pre-existing and all health conditions.

It is also your responsibility to inform us of any discomfort during any session.

I _____ understand and accept any risks of which I have been advised associated with the agreed upon skin treatment. I release Maria Keith from all liability arising from any injury and/or damage from failure to inform her/him of any pre-existing conditions, limitations, specific sensitivities, and/or any discomfort during the treatment.

I agree to keep Aesthetics.y.k & Daniels Vein & Cosmetic Center updated as to any changes in my medical profile.

Client Signature: _____Date: _____

Parent or Guardian: _____Date: _____

PHOTOGRAPH CONSENT

**Photographic documentation will be taken.

I hereby DO __ DO NOT __ authorize the use of my photographs for teaching and/or website purposes.

Client Signature: _____Date: _____

Parent or Guardian: _____Date: _____

PATIENT DEMOGRAPHIC INFORMATION AUTHORIZATION

Daniels Vein & Cosmetic Center is participating in the U.S. Department of Health and Human Services' "Meaningful Use" program in order to provide better patient care. This program will lead to improved electronic communications and a more complete medial record for our patients.

Please choose one from each section:

Race:

□ American Indian or Alaskan Native

□ Asian

□ Black or African American

□ Native Hawaiian or Other Pacific Islander

□ White

□ Unknown/Other _____

□ I prefer not to report

Ethnicity:

□ Hispanic or Latino

□ Not Hispanic or Latino

□ I prefer not to report

Primary Language:

□ English

□ French

□ German

□ Spanish

□ Italian

□ Portuguese

□ Polish

□ I prefer not to report

□ Other Language _____

I, _____(Print Name), hereby authorize Daniels Vein & Cosmetic Center to: (1) use the demographic information listed above for purposes of completing my electronic health record; (2) disclose such information to government officials and third parties as necessary to comply with state and federal laws and regulations; (3) use and/or disclose such information in connection with demonstrating the Practice's meaningful use of EMR technology; and (4) use and/or disclose such information as described in the Practice's HIPPA policies and procedures, and as otherwise permitted by HIPPA laws and regulations.

_____ _____