valley SURGICAL, AESTHETICS & VEIN CARE
BRAD A. CASE, MD

Patient Registration

TODAYS DATE: _____ PHONE NUMBER: _____

PRINT FULL NAME: _____

MAILING ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____ SSN: _____

SEX: M ____ F ____ SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ PHONE:_____

NOTIFY IN CASE OF EMERGENCY: _____ PHONE: _____

E-MAIL ADDRESS: _____

IF MEDICAL/SURGICAL VISIT:

PRIMARY INSURANCE: _____

SUBSCRIBER NAME: _____ RELATIONSHIP: _____

SUBSCRIBER D.O.B.:_____ SUBSCRIBER SSN: _____

MEMBER ID: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____

SUBSCRIBER NAME: _____ RELATIONSHIP: _____

SUBSCRIBER D.O.B.:_____ SUBSCRIBER SSN: _____

MEMBER ID: _____ GROUP NUMBER: _____

PATIENT EMPLOYMENT: _____ PHONE: _____

IF MARRIED, SPOUSE'S NAME: _____

SPOUSE'S EMPLOYMENT: _____ PHONE: _____

PERSON RESPONSIBLE FOR BILL: _____

REFFERED BY: _____

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BRAD A. CASE, MD

Today's Date _____

Name _____ Age _____ DOB _____

Address _____ City _____ Zip _____

Home Phone _____ ☐ OK to Contact/Leave Message Here

Work Phone _____ ☐ OK to Contact/Leave Message Here

Mobile Phone _____ ☐ OK to Contact/Leave Message Here

Email _____ ☐ OK to Contact/Leave Message Here

☐ I would like to receive email notifications of new products, services, events and promotions

Occupation _____

Emergency Contact _____ Phone _____

Reason for Visit _____

Referred By _____

With 1 being the most important, make a wish list of what you would like to see improved in your skin in the next 80 days:

☐ Reduction of fine lines ☐ Reduction of hair ☐ Reduction of redness

☐ Reduction of oil/acne ☐ Acne scars diminished ☐ Reduction of brown spots/ sun Damage

Other topics that interest you (check all that apply)

☐ Skin rejuvenation ☐ Laser hair removal ☐ Removing facial veins

☐ Age spots or brown spots ☐ Facials & eye treatments ☐ Chemical peels

☐ Skin care advice & products ☐ Acne or acne scars ☐ Microdermabrasion

☐ Laser resurfacing ☐ HydraFacial ☐ Body contour/ skin tightening

☐ Botox ☐ Retin-A ☐ Dermal fillers (Juvederm, Voluma)

Medical History	**Yes**	**No**
Are you or is it possible that you may be pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Do you form thick or raised scars from cuts or burns (e.g., keloids)?	☐	☐
After injury to the skin do you have: Darkening of the skin in that area?	☐	☐
Lightening of the skin in that area?	☐	☐
Hair removal by plucking, waxing, electrolysis in the last 4 weeks?	☐	☐
Tanning (tanning bed) or sun exposure in the last 4 weeks?	☐	☐
Tanning products or spray tan in the last 2 weeks?	☐	☐
Do you have a tan now in the area to be treated?	☐	☐
Do you use sunscreen **daily** with SPF30 or higher?	☐	☐
Do you or any member of your family have skin cancer or a history of skin cancer? If yes whom? What type of skin cancer?	☐	☐
Have you ever had a photosensitive disorder (e.g., lupus)?	☐	☐
History of seizures?	☐	☐
Permanent makeup or tattoos? Where?	☐	☐
Have you used Accutane in the last 6 months?	☐	☐
Are you currently taking antibiotics? Which ones?	☐	☐
Are you using Retin-A or glycolic acid products? (circle)	☐	☐
Are you currently under the care of a physician for your skin? Why?	☐	☐

Medical History (Continued)	**Yes**	**No**
Do you currently smoke?	☐	☐
Do you have an allergy or sensitivity to lidocaine, latex, sulfa medications, aspirin, hydroquinone, aloe, or bee stings? (circle)	☐	☐
Life threatening allergy to anything?	☐	☐
Have you ever had an allergy or sensitivity (rash, irritation, swelling, peeling, hives) to cosmetics, fabrics, medications, food, latex or otherwise? List all allergies:	☐	☐
Do you have scars on the face?	☐	☐
Have you ever had any aesthetic or facial surgery? What type and when?	☐	☐
Are you using Fluorouracil?	☐	☐
Do you "flush" or appear easily red when you eat spicy food, drink alcohol Or go under the sun?	☐	☐
Do you have any vascular concerns (i.e., telangiectasia or broken capillaries)? Where?	☐	☐
Do you have a history of acne or periodic breakouts?	☐	☐
Do you have acne scars?	☐	☐
Do you experience breakouts only during your menstrual cycle?	☐	☐
Do you always have a pimple or some type of breakout?	☐	☐
Have you done any aggressive exfoliation (e.g., chemical peel, microdermabrasion) In the last 4 weeks? If so, have you had any problems?	☐	☐
Have you had a depilatory procedure or waxing procedure done within the last 6 weeks? If so, where?	☐	☐
Have you ever had cold sores? If so, when was the last?	☐	☐
Have you ever had herpes (including genital herpes)? If so, when was the last outbreak?	☐	☐
Do you bruise or bleed easily? If so, where?	☐	☐
Do you have an active skin infection? If so, where?	☐	☐
Do you have any unusual moles or moles that changed, itched or bled? If so, where?	☐	☐
Have you had any increases in the amount of hair anywhere on your body? If so, where?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies or allergic rhinitis?	☐	☐
Do you have eczema or dermatitis? If so, where?	☐	☐
Do you have hypo- or hyperthyroidism? If so, indicate which one	☐	☐
Do you experience poor healing?	☐	☐
Do you or any member of your family have, or have a history of, diabetes?	☐	☐
Do you or any member of your family have, or have a history of heart problems?	☐	☐
Do you have a disease of nerves or muscles (e.g., ALS, rheumatoid arthritis, scleroderma)? If so, please list	☐	☐
Do you have a pacemaker?	☐	☐
Do you have high blood pressure?	☐	☐
Do you have hepatitis?	☐	☐
Do you have shingles?	☐	☐
Do you get migraines? If so, how often? Any known triggers?	☐	☐

Do you have any health problems or medical conditions not listed? If so, please explain.

Have you ever been treated with any of the following (check all that apply)? If so, when? Did you have any problems? ☐ Botox ☐ Xeomin ☐ Collagen/ Restylane/ Juvederm

What is your skin type?

☐ Dry ☐ Oily ☐ Combination ☐ Sensitive ☐ Acneic ☐ Other (please explain) _____

How do you tan? ☐ Burn ☐ Rarely Burn ☐ Usually Burn ☐ Sometimes Burn ☐ Never Burn – "Brown" ☐ Never Burn – "Black"

Please list any current medications, prescriptions, or over-the-counter supplements or herbals that you currently take:

All aesthetics procedures are considered cosmetic and must be paid for in full at the time of service. All sales on procedures and product (unless there is a reaction from product within 7-10 days of purchase) are final.

☐ I certify that the medical information I have given is complete and accurate

Signature_____ Date _____

☐ **I authorize the use of my photos.**

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BRAD A. CASE, MD

Valley Surgical, Aesthetics & Vein Care:Dr. Brad Case
Diplomate, American Board of Surgery
Fellow, American College of Surgeons

AUTHORIZATION FOR EXAMINATION

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PRIMARY CARE PHYSICIAN (If medical): _____

I, _____, represent to the physicians and staff that I am 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I authorize that taking photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

Have you been or are you currently involved in litigation? Yes [ ] No [ ]

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

Signature: _____ Date: _____

Witness: _____ Date: _____

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Your appointment times are very important to us at Valley Surgical, Aesthetics and Vein Care; it is reserved especially for you, we understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 48 hours-notice for cancellations.

STRICT AND ENFORCED 48 HOUR CANCELLATION POLICY

Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and patients on our waiting list miss the opportunity to receive services or treatments. Our appointments are confirmed 48 hours in advance because we know how easy it is to forget an appointment you booked months ago. Since the services are reserved for you personally, a Cancellation fee will apply.

Less than 48 hour notice and/or NO SHOWS will result in a charge of $75 for a technician and $125 for Dr. Case's time (this charge is not covered by insurance).

The cancellation policy allows us the time to inform our standby patients of any availability, as well as keeping our staff members schedule filled, thus better serving everyone.

CONFIRMATION CALLS

As a courtesy, we will call and confirm your appointments two days prior to your appointment date. However, if we are unable to reach you, and can only leave a message, please understand that it is your responsibility to remember your appointment dates and times to avoid late arrivals, missed appointments and the cancellation fee. You will also receive a reminder email from our scheduling software 48 hours prior to your scheduled appointment.

LATE ARRIVALS

Should you be running more than 10 minutes late for your appointment, please understand that we may have to reschedule your appointment which could incur a fee.

_____ _____

Patient's Printed Name Date

_____

Patient's Signature