THE JACKSON CENTER
FOR AESTHETIC SURGERY AND DERMATOLOGY

Patient Information

Name (First Middle Last) _____

Local Address _____

Home Phone _____ Cell Phone _____ Other Phone _____

Date of Birth _____ SS# _____ Marital Status Widowed

Employer _____ Work Phone _____

Billing Address _____

Emergency Contact _____ Phone _____

Pharmacy of Choice _____ Phone _____

Primary Care Physician _____ Phone _____

Referred By _____

Insurance and Subscriber/ Responsible Party Information (if different from patient)

Primary Insurance _____ **Secondary** Insurance _____

Name (First Middle Last) _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ SS# _____ Relationship of Patient to Insured _____

Financial Policy

It is the policy of The Jackson Center, PA that the patient or the patient's legal guardian is solely responsible for all fees incurred during treatment. When applicable, insurance co-pays, co-insurances, and/or deductibles may be collected at the time services are rendered. For in-network patients, The Jackson Center will bill the patient's insurance carrier and accept the carrier's allowable for the services rendered. For out-of-network patients, The Jackson Center will bill the patient's insurance carrier, but will not accept the carrier's allowable for the services rendered. The out-of-network patient will be responsible for the difference between what The Jackson Center charges and what the insurance carrier pays to The Jackson Center. The Jackson Center cannot guarantee that the patient's insurance carrier will make any payment, either partial or complete, for the services rendered. It is each patient's responsibility to check with their insurance carrier as to the network status of The Jackson Center and to verify their out-of-pocket expense. Non-medically necessary (cosmetic) services will be the patient's responsibility and will not be billed to an insurance carrier. Self-pay patients will be required to pay in full at the time services are rendered. Your signature below indicates that you understand our policies and accept financial responsibility for payment of all services rendered.

Patient/Responsible Party Signature _____ **Date** _____

A patient photograph will be taken to be part of the medical record.

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Current Medications (Please include over-the-counter meds and vitamins)

1.	4.	7.
2.	5.	8.
3.	6.	9.

Medication Allergies

☐ No known medication allergies

1.	☐rash	☐difficulty breathing	☐vomiting/stomach upset	☐other:
2.	☐rash	☐difficulty breathing	☐vomiting/stomach upset	☐other:
3.	☐rash	☐difficulty breathing	☐vomiting/stomach upset	☐other:

Medical History (Please fill in a circle to answer each question)

Y	N		Y	N		Y	N		Y	N	
○	○	Basal cell skin cancer	○	○	Autoimmune disease	○	○	Heart attack	○	○	Pacemaker/Defibrillator
○	○	Squamous cell skin cancer	○	○	Congestive heart failure	○	○	Heart valve abnormality	○	○	Psoriasis
○	○	Melanoma	○	○	Coronary artery disease	○	○	Hepatitis B or C	○	○	Reflux disease
○	○	Abnormal bleeding	○	○	Dementia	○	○	HIV positive	○	○	Renal disease
○	○	Actinic keratosis	○	○	Diabetes	○	○	High blood pressure	○	○	Seasonal allergies
○	○	Anemia	○	○	Eczema	○	○	Internal malignancy	○	○	Seizure disorder
○	○	Arrhythmia	○	○	Emotional disorder	○	○	Joint replacement surgery	○	○	Stroke
○	○	Arthritis	○	○	Emphysema/COPD	○	○	Liver disease	○	○	Thyroid disease
○	○	Asthma	○	○	Glaucoma	○	○	Migraines	○	○	Other serious illness

Surgical History (Please list all surgeries and dates performed)

1.	3.	5.
2.	4.	6.

Family Medical History (Please fill in one or more circles to answer each question)

Parents:	○ Basal cell carcinoma	○ Squamous cell carcinoma	○ Melanoma	○ No history of skin cancer
Siblings:	○ Basal cell carcinoma	○ Squamous cell carcinoma	○ Melanoma	○ No history of skin cancer

Review of Systems – Active Problems Only (Please fill in a circle to answer each question)

Y	N		Y	N		Y	N		Y	N	
○	○	Chest pain	○	○	Fatigue	○	○	Nausea	○	○	Weight gain
○	○	Depression	○	○	Fever	○	○	New/worrisome moles	○	○	Weight loss
○	○	Difficulty swallowing pills	○	○	Headache	○	○	Nosebleeds	○	○	Wheezing
○	○	Dizziness/fainting	○	○	Heartburn	○	○	Palpitations	**Women Only**		
○	○	Dry/sensitive skin	○	○	Itching	○	○	Shortness of breath	○	○	Currently pregnant
○	○	Eye irritation	○	○	Mood swings	○	○	Skin rash	○	○	Irregular menses

Social History (Please fill in one or more circles to answer each question)

Do you: Smoke tobacco? ○ None ○ ½ or less ○ 1 ○ 1½ ○ 2 or more (packs/day)
○ Quit this month ○ Quit this year ○ Quit 1-5 years ago ○ Quit >5 years ago

Drink alcohol? ○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ more than 5 (drinks/day)

Occupation: Hobbies:

Patient Name _____ Submit by Email Date _____