

Please print .

Last Name:		First Name:		Preferred Name:	
Mailing Address:		City	State	Zip Code	
Residence Address:		City	State	Zip Code	
Part time HI resident? (circle one) Yes No		If yes, what state?		Mainland Phone:	
Birth Date:	Social Security #	<input type="checkbox"/> Male	Marital Status: (circle one)		
		<input type="checkbox"/> Female	Single Married Divorced Widowed		
Home Phone:	Cell Phone:	E-mail (for appointment reminders and promotions):			
Work Phone:	Occupation:	Employer:			
Whom should we thank for referring you? <input type="checkbox"/> Maui News <input type="checkbox"/> Maui Bulletin <input type="checkbox"/> Family Magazine <input type="checkbox"/> Google <input type="checkbox"/> Yahoo <input type="checkbox"/> Drive-by					
Friend _____ Family _____ Doctor: _____ Other _____					
Name of Primary Care Physician:					
Emergency Contact:		Relationship:		Phone:	

*** Please present insurance card to staff ***

Do you have <u>Medical Insurance</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Insurance (please present your card):			Is this through your employer? (circle one) Yes No
Subscriber's Name on Card:		Subscriber's Birth Date:	Policy/ID Number:
Name of <u>Spouse</u> :		Birthdate of Spouse:	
Do you have secondary insurance ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Secondary Insurance:		
Subscriber's Name:		Subscriber's Birth Date:	Policy/ID Number:
Person <i>financially responsible</i> for this account: ----→ <input type="checkbox"/> Self <input type="checkbox"/> Other _____ (address- →)		Address:	

*** If the client is a **minor (under 18 years of age)** → **Who is the responsible person:** _____

Mother's name:	Street address, City, State, Zip:	Home Phone:
Mother's Occupation / Employer:	Work phone:	Does the patient live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Father's name:	Street address, City, State, Zip:	Home Phone:
Father's Occupation / Employer:	Work phone:	Does the patient live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Who may authorize treatment? _____		
Do you have an answering machine at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Prefer contact/messages via cell phone?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		
May we leave message(s) from this office on the machine ? <input type="checkbox"/> Yes <input type="checkbox"/> No. May we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand I am responsible for all charges regardless of insurance coverage. By signing this section, I assign payment of benefits provided by the group plan directly to Micki Ly, MD. I further agree that a photocopy/scanned document of the agreement shall be as valid as the original in the event of a dispute or a default. **I agree to pay all cosmetic consultation fee/copays/deductible and reasonable collection charges, late fees, and/or attorney fees.** I agree to comply with the Office Policy Terms & Conditions which is avail. upon request and posted in the waiting room. All information provided is accurate to the best of my knowledge and I agree to all terms as above. I agree to update the office with name/address/insurance changes or incur admin. fees.

Signature (Over age 18 only): **X** _____ (please check) Client Parent/Guardian
 Print Name: _____

Name: _____

Missed appointments policy: In order to provide quality service and availability to all of our patients, it is our policy to charge an office visit fee (\$80.00) for appointments not cancelled at least 24 hours in advance. Please call 877-6526 if you need to reschedule your appointment.

Medical History

Surgeries & when: _____ _____ _____ _____ _____	Medications: _____ _____ _____ _____ _____
Allergies: _____ _____ _____	If you have an artificial heart valve, joint, or other prosthesis that requires you to take antibiotics when you have dental procedures, please list what device / antibiotics usually prescribed: _____ _____
Are you allergic to: (circle all that apply) Tape BandAids Adhesives None	Female patients only: Are you on oral contraceptives (birth control pills)? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you pregnant or trying to become pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you smoke? <input type="checkbox"/> No. Quit smoking, when? _____ <input type="checkbox"/> Yes - How long / how much a day? _____	Do you drink? <input type="checkbox"/> No. Quit drinking, when? _____ <input type="checkbox"/> Yes - Socially Light drinking Heavy drinking
History of drug abuse? If so, please describe. _____ _____	

*** Circle medical problems that you have/had ***

Asthma	Blistering Sunburns	Bleeding Tendency	Cataracts
Diabetes	Eczema	Glaucoma	Hayfever
Heart Attack	HIV	Basal Cell Cancer	Squamous Cell Cancer
Hypertension	Lupus	Hepatitis (Type: A / B / C)	Melanoma (Depth ____)
Mitral Valve Prolapse	Psoriasis	Cancer (non-skin) Type: _____ Date: _____	
Other:		Treatment: _____	
Any other medical history not listed: _____ _____			

We offer a full range of cosmetic procedures. Please indicate if you are interested in learning about these anti-aging enhancements.

- | | |
|--|---|
| <input type="checkbox"/> Facial wrinkles, lines, sags, and hollow reduction
(Restylane Fillers / Radiesse / Juvederm / Artefill / Evolence)
<input type="checkbox"/> Worry lines, forehead wrinkles, crows feet (Botox)
<input type="checkbox"/> Lip enhancement <input type="checkbox"/> Tattoo removal
<input type="checkbox"/> Hair removal <input type="checkbox"/> Skin tag, mole removal
<input type="checkbox"/> Acne solution <input type="checkbox"/> Blotchy rough skin solution | <input type="checkbox"/> Photofacial (IPL) for younger, tighter, and smoother skin,
<input type="checkbox"/> Laser for skin tightening
<input type="checkbox"/> Chemical peel for smoother even toned skin
<input type="checkbox"/> Liposuction, body contouring
<input type="checkbox"/> Facial broken blood vessels <input type="checkbox"/> Varicose veins
<input type="checkbox"/> Brown spots <input type="checkbox"/> Spider veins |
|--|---|

I hereby acknowledge that I have read this information and have provided you my medical information to the best of my knowledge. I agree to all of the provisions contained herein. I agree to pay my estimated copay/consultation fee on the date of service, as well as applicable deductible and remaining copays and applicable late fees. I agree to the terms of the Office Policy & Conditions available upon request and posted in the waiting room. I realize the email usage is for confirmation of appointment time and promotions/savings announcements.

Signature (Over age 18 only): **X** _____ (please check) Client Parent/Guardian
 Print Name: _____