Westlake Laser and Aesthetics
Patient Registration

1240 s Westlake Blvd Suite # 102Westlake Village CA 91361
(805) 497-7546
www.Westlakelaser.com

Date: _____ Home Phone_____

Email _____ Cell Phone _____

Patient: _____

First Last Name MI

Street Address _____

City _____State_____ Zip_____

- Sex: M F Age _____ Birthdate _____ Are you a Brilliant Distinctions member? Yes No

Dermatology Insurance patients only

Do you have medical insurance? Yes (fill out information below) No (do not fill out bellow)

Purpose of Visit_____

Patient Social Security # _____ Driver's License # _____

Name of Insurance Company _____

Spouse (or Responsible party) _____Social Security _____

Employed by _____Subscriber ID #_____Group #_____

In case of emergency who should be notified _____Phone #_____

How did you learn about our practice? _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I fully understand that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____to pay and herby assign directly to pay
(Name of Insured) *(Name of Insurance Company)*

and hereby assign directly to _____all benefits, if any, otherwise payable to me for his/her services as described
(Providers Name)

on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits,

when received by and paid to _____will be credited to my account, in accordance with the above said assignment.
(Providers Name)

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THIS MEDICAL HISTORY QUESTIONNAIRE IS NECESSARY FOR PHYSICIAN USE ONLY, IT IS PRIVATE AND CONFIENTIAL.

Name _____ Date _____

1. Are you allergic or sensitive to any medications? **Y** **N**

If yes please list **all allergies**regardless of what you are being treated for today:

_____

_____

2. Are you allergic to Xylocaine or Novocain? **Y** **N**
3. Have you ever been told you bleed more than normal? **Y** **N**
4. Do you bruise easily? **Y** **N**
5. Are you allergic or sensitive to tape? **Y** **N**
   - If yes, Itchy? _____ or redness? _____
6. Have you ever had any general anesthetic? **Y** **N**
   - If yes, were there any problems?

     _____
7. Are you under treatment for any medical condition? _____
8. When did you last complete your last physical exam? _____by whom?_____
9. When was your last chest x-ray? _____
10. Have you ever had any serious prolonged illness? **Y** **N**
    - If yes, what and when?

      _____

      _____
11. List operations, serious injuries and accidents, giving dates and names of hospitals.

    _____

    _____
12. Where there any complications from surgery, such as bleeding or infections?

    _____
13. Ht? _____ What? _____Have recently lost or gained any weight?

    _____
14. Do you use eye drops? **Y** **N**
15. Do you take any contraceptive pills? **Y** **N**

16. **FAMILY HISTORY**

Relation	***If Living Age***	***State of Health***	***If Deceased Age***	***Cause of Death***
Father				
Mother				
Brothers				
Sister				

17. Has any blood relative (grand parent, parent, brother, sister, child, etc.)

Condition	***NO***	***YES***	***Relationship***
Cancer?			
High blood pressure?			
Heart disease?			
Excessive bleeding?			
Diabetes?			

18. Have you ever had any x-ray treatment to your head or neck? **Y** **N**
19. Have you ever had thyroid trouble? **Y** **N**
20. Do you take Valium? **Y** **N** How much? _____
21. Do you take sleeping pills? **Y** **N** How often and how much? _____
22. What medication or drugs are you currently taking? _____
23. Do you smoke? **Y** **N** How much? _____
24. Do you use alcohol? **Y** **N** If yes how much? _____
25. Have you ever had a serious or chronic condition? If yes please give details.

    _____

    _____
26. Have you ever had Hepatitis? **Y** **N**
27. Have you ever had colitis, ulcers or gastritis?**Y** **N**