PATIENT INFORMATION

Name_____

Address_____ Zip Code_____

Email Address_____

Home phone _____Cell Phone_____Work phone_____

Alternate address _____ Alternate phone _____

Date of Birth _____ Age _____ Sex_____

Employer _____

Legal Guardian _____ DOB _____
(If patient is minor)

How did you learn about this practice?_____

Primary Care Physician Name: _____Phone Number_____

Referring Physician:_____ Phone Number_____

I authorize release of medical or other information to insurance companies/carriers required to process insurance claims. I acknowledge and accept responsibility for full payment of services.

_____ _____
Signature ***Date***

I have read a copy of* HIPAA *Notice of Privacy Practices. Dr. Fabian & Associates may release medical information to the following:

Spouse _____

Children _____

Parent _____

Other _____

_____ _____
Signature Date

MEDICAL HISTORY

PATIENT'S NAME _____ DATE _____

Why are you seeing the Doctor?_____

Prescription and Over-The-Counter Medications

NAME	DOSE	FREQUENCY

Drug Allergies_____

Medical History (please circle)

Diabetes	Hypertension	Coronary artery disease	Joint Replacement
Stroke	Arthritis	Valvular heart disease	Radiation therapy
Lung disease	Bleeding disorder	Arrhythmia	Depression/Anxiety
HIV/AIDS	Leukemia/Lymphoma	Pacemaker/Defibrillator	Drug/Alcohol
Hepatitis	Kidney Disease	Thyroid Disease	Fainting Problems

Other _____

Surgical History:_____

MEDICAL HISTORY

PATIENT'S NAME _____ DATE _____

Do you have a history of skin cancer (please circle type): melanoma, basal cell carcinoma, squamous cell carcinoma

Internal Cancer (type) _____

Do you have a family history of skin cancer?_____

Do you smoke? ____How Much?_____ Do you drink alcohol? _____How Much?_____

Do you have an Advance Care Plan (Living Will)? YES or NO

If yes, who is your surrogate?_____

Did you receive the flu vaccine before this past flu session? YES or NO

Have you ever received the pneumonia vaccine? YES or NO

PHARMACY:

Name _____Phone #_____

Location:_____

GENERAL CONSENT

Patient Name _____

I give Dr. Fabian & Associates consent to evaluate and treat me. This may include treatment of a variety of benign, cosmetic, premalignant or malignant lesions. The procedures used may include but are not limited to biopsies with or without stitches, excisions with or without stitches, scraping and burning known as electrodesiccation and curettage, freezing with liquid nitrogen, incisions with or without drainage, dermabrasion also known as sanding, injection of local anesthetics, injection of steroids, injection of Botox and fillers.

Each procedure involves risks that may include but are not limited to bleeding, bruising, swelling, pain, blistering, discoloration, infection, scarring, numbness, muscle paralysis, thinning of skin (atrophy), reaction to anesthesia failure to resolve.

Dr. Fabian & Associates will advise you of the procedure he recommends, you are encouraged to ask questions before anything is done to avoid any miscommunication. Dr. Fabian and/or his staff will review wound care instructions after the procedure is performed and you are again encouraged to ask questions if you do not understand or need further clarification.

You can refuse any procedure. However if a lesion is premalignant, it may progress to a malignancy without treatment. A known or suspected malignancy that is not treated can lead to serious health problems including death. If you refuse a biopsy of a suspicious lesion there is a risk that it may be a skin cancer which left untreated will lead to health problems as previously mentioned.

Dr. Fabian & Associates make no guarantee as to the outcome of any procedure.

Signature of Patient _____

Date _____