Congress Cosmetic Medical Corp.
10 Congress Street, Suite 320
Pasadena CA 91105
(626)585-9474

Today's Date____/___/_____

PATIENT INFORMATION ☐ New Patient ☐ Update ☐ Change of Information (Address, Insurance)

Name_____DOB____/____/____ Age_____ ☐Male ☐Female
Last First Middle Inital

☐Minor ☐Single ☐ Married ☐Divorced ☐Widowed ☐Partnered

Address_____City_____State_____Zip_____

Home Phone ( )_____-_____ Cell ( )_____-_____ Email Address_____@_____

Employer _____Occupation_____ Work ( )_____-_____

Emergency Contact:_____Relationship to Patient_____ Phone ( )_____-_____

Referred by: _____

Ethnic Group/Race_____☐ Decline to Specify ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Language_____ In case of emergency who should be notified_____( )____-____

PRIMARY INSURANCE

Subscriber Name/Responisble Party_____Relationship to Patient_____

Insurance Company_____

Member ID #_____ Group #_____

SECONDAY INSURANCE

Insurance COmpany/Responsible Party_____Relationship toPatient_____

Insurance Company_____

Member ID #_____ Group #_____

ASSIGNMENT AND RELEASE

I understand that if I have **Medicare, Anthem Blue Cross PPO/Blue Shield PPO insurance**, I assign benefits directly to Congress Cosmetic Medical Corp. I am fully responsible for my deductible and co-payments. CCMC will collect at time of service for cosmetic or benign lesions treatments. It is my responsiblitity to provide updated insurance and personal information at each visit. A minor must have an adult present for treatment. **I must cancel within 24 hours or will be charged a $50.00 fee**. I agree with these policies.

Signature of Patient/Patient Representative_____Relation to Patient_____

Printed Name of Patient/Patient Representative_____Date_____

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HEALTH HISTORY

Patient Name_____DOB____/____/_____Today's Date_____/_____/_____

Reason for today's visit_____

Please check any conditions you have or have had:

Systemic
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Cancer_____
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ HIV/Hepatitis
- ☐ Gastrointestinal Condition
- ☐ Other _____

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Cancer_____
- _____ ☐ Herpes

Women Only

Vaccinations

Pregnant ☐ Yes_____months ☐ No
- ☐ Flu Shot____/____/____
- ☐ Pneumonia
- ☐ Chicken Pox/Measles____/____/_____

Respiratory
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Other_____

Neuro
- ☐ Stroke
- ☐ Epilepsy/Seizure
- ☐ MS/Other_____

Family History

Father_____

Mother_____

Brother_____

Sister_____

- ☐ Do you Smoke
- ☐ Do you drink Alcohol_____per day
- ☐ IV Drugs

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Irregular Heartbeat
- ☐ Hx. of Heart Attack
- ☐ Other_____

Psychiatric Care
- ☐ Depression/Anxiety
- ☐ Mental Disorder

Surgeries/Hospitalization/Other

_____

_____

Social History

Number of children_____

Men Only
- ☐ Prostate Disease ☐ Cancer

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list_____

List all medications you are currently taking (include over the counter medications, vitamins, herbs):

1._____2._____3._____4._____

5._____6._____7._____8._____

☐ **See Attached List Provided.**

Pharmacy Information:

Name_____Phone Number( )_____-_____Fax Number( )_____-_____

Address_____City_____Zip_____

Signature of Patient/Patient Representative_____