Beckman Laser Institute Medical Clinic

UC Irvine Medical Center

Patient Information				
First Name:	Middle:	Last:	Date Of Birth:	Sex:
Address: Street		City:	State:	Zip:
Home Phone: ( )		Work Phone: ( )		Ext.
Social Security Number: - -		Driver License Number:		
Current Employer Name:		Occupation:		
Employer Address: Street		City:	State:	Zip:

Responsible Party Information				
First Name:	Middle:	Last:	Date Of Birth:	Sex:
Relationship To Patient		Home Phone Number: ( )		
Address: Street		City:	State:	Zip:
Employer Name:		Occupation:		
Employer Address Street		City:	State:	Zip:
Work Phone: ( ) Ext.		Social Security Number: - -		Drivers License # :

Medical Insurance Information				
First Name Of Insured:	Middle:	Last:	Phone Number: ( )	
Policy # / Group #/ Contract ID Number			Social Security # Of Insured: - -	
Claims Address / P O. Box # :		City:	State:	Zip:

Emergency Contact Information				
First Name:	Middle:	Last:	Relationship to Patient:	
Address: Street:		City:	State:	Zip:
Home Phone Number: ( )		Work Phone Number: ( )		Ext.

Authorization: I hereby authorize the physician to furnish information to insurance carriers concerning illness / accident, and I hereby irrevocably assign to the doctor/facility payments for medical services rendered I understand that I am financially responsible for all charges whether or not covered by the insurance A copy of this authorization shall be considered as valid as the original

Signature of Patient / Guardian _____ Date _____

UCIMC SURGERY LASER CLINIC

MEDICAL HISTORY

NAME:_____ DATE:_____
REFERRING DOCTOR:_____ D.O.B.:_____
CHIEF COMPLAINT:_____

SOCIAL HISTORY:

BIRTHPLACE:_____
CURRENT RESIDENCE:_____
OCCUPATION:_____
CURRENT MEDICATION:_____

MEDICAL HISTORY:	YES	NO	IF YES, EXPLAIN
ALLERGIES OR DRUG REACTION	____	____	_____
HOSPITALIZATION	____	____	_____
SURGERIES	____	____	_____
INJURIES	____	____	_____
HYPERTENSION	____	____	_____
DIABETES MELLITUS	____	____	_____
SOCIAL DRUGS	____	____	_____
TOBACCO	____	____	_____
PAST HISTORY OF:			
LIVER DISEASE	____	____	_____
HEART DISEASE	____	____	_____
KIDNEY DISEASE	____	____	_____
ULCER DISEASE	____	____	_____
LUNG DISEASE	____	____	_____
ARTHRITIS	____	____	_____
STROKE	____	____	_____
BLEEDING DISORDERS	____	____	_____
ANEMIA	____	____	_____
RESPIRATORY PROBLEMS	____	____	_____
GASTROINTESTINAL PROBLEMS	____	____	_____
URINARY PROBLEMS	____	____	_____
GENITAL/GYN. PROBLEMS	____	____	_____
PSYCHOLOGICAL PROBLEMS	____	____	_____
SEXUAL PROBLEMS	____	____	_____
EYE PROBLEMS	____	____	_____
DERMATOLOGY PROBLEMS	____	____	_____

DO YOU HAVE AN ADVANCE DIRECTIVE? (A living will or living Trust) ___yes___no