



Clovis Manley, MD
4943 Rosebud Lane
Newburgh, IN 47630
(812) 490-SKIN (8346)

Medical History and Skin Care Questionnaire

Name _____ Date of Birth _____ Sex _____ Date _____ Age _____

How did you first hear of us? (check all that apply):

- TV Radio Internet Search Website Physician _____
 Family/Friend Newspaper Social Media _____ Other _____

Who can we thank for referring you to us? _____

If you would like to be added to our email blast to learn about specials, promotions etc., please list your email address: _____

Medical History

Medical Conditions: (check any condition that applies to you or list them below):

- | | | | |
|-----------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer- Type _____ | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Neurological disease |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Lupus | <input type="checkbox"/> Myasthenia gravis |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Raynaud's | <input type="checkbox"/> Migraine headaches |
- _____
 • _____
 • _____
 • _____

Surgical History (please list past surgeries, non-cosmetic)

- _____
 • _____
 • _____

Current Medications: (list all prescriptions, over the counter, herbal, vitamins, & supplements)

- _____
 • _____
 • _____
 • _____

Medication Allergies _____ None

Other Allergies/Sensitivities (check all that apply):

- Aspirin Metal Latex Caines (lidocaine, benzocaine)

Health Risk Assessment

- Use of tobacco: Cigarettes Age started _____ Packs/amount per day: _____
 Never used it Cigars Age Stopped _____
 Used to but quit Pipe
 Still use it Snuff/chew

What describes your use of alcoholic beverages? (may choose more than one)

- Never a drinker 1-2 drinks weekly Drink heavy on weekends only I need help
- 1-5 drinks per year 1-2 drinks daily Heavy drinker all week Former drinker
- 1-2 drinks per month 3 or more drinks daily One/both of my parents are alcoholics

Women Only (check all that apply):

- Hysterectomy Tubal ligation I could be pregnant Post-menopause
- Pregnant : Due date ____/____/____ Nursing until: ____/____/____
- First day of your last menstrual period ____/____/____ Type of birth control used _____

Skin Care Questionnaire

Skin History (check all that apply)

- Precancerous skin lesion Keloids Herpes, cold sores Eczema
- Recurrent Skin Rash Acne Ulcers Psoriasis
- Skin cancer (if so circle all that apply) Squamous, Basal cell, Melanoma Sun Poisoning

Have you ever taken Accutane? No Yes When was your last dose ____/____/____

When in the sun for one hour without protection do you (circle one).....I Always burn and never tan
 II Always burn and sometimes tan
 III Sometimes burn and sometimes tan
 IV Never burn and always tan
 V Asian, Mediterranean, Hispanic
 VIAfrican American

Present Skin Conditions (check all that apply)

- Brown Spots or Age Spots Skin Pigmentation Problems Whiteheads or Blackheads
 - Facial Redness Broken Facial Capillaries Fine Lines & Wrinkles
 - Oily Skin Clogged Pores Leg Spider Veins or Varicose Veins
 - Dry, Flaky Skin Moles you would like removed Crusty or Scaly areas that never heal
 - Unwanted Tattoos Melasma Moles that have changed shape or color
 - Acne Scarring Enlarged Pores Rosacea
 - Uneven Texture Lax or Sagging Skin Dark Under-Eye Circles
- Excessive Sweating (if so circle all that apply) Hands, Feet, Scalp, Underarms

Do you currently see a dermatologist? No Yes (Why?) _____

Do you bruise easily? No Yes

What type of skin do you think you have? Dry Normal Combination Oily

Have you ever had a reaction to any skin care product? No Yes (what?) _____

What skin care products do you use during your daily routine? (include soaps, moisturizers, oils, etc)

Morning

Evening

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Are you happy with your current skin care products? No Yes

Cosmetic History (please list dates when applicable)

	Yes	No	Date
Facial Plastic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Other Cosmetic Surgery (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Dermal Filler Injections (what product?) _____	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Botox® or Other Toxins (what toxin?) _____	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Chemical Peels	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Dermaplane or Microdermabrasion.....	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Skin Resurfacing (CO2, Microlaserpeel, etc).....	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Photorejuvenation (BBL and/or IPL).....	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Laser Treatment of Veins.....	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Sclerotherapy (injection) of veins.....	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _
Coolsculpting.....	<input type="checkbox"/>	<input type="checkbox"/>	_ / _ / _

Which of the the following areas are you interested in making improvements? (check all that apply)

- | | | | | |
|------------------------------------|------------------------------------|--------------------------------|----------------------------------|---|
| <input type="checkbox"/> Eyelashes | <input type="checkbox"/> Lips | <input type="checkbox"/> Nose | <input type="checkbox"/> Neck | <input type="checkbox"/> Double chin |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Arms | <input type="checkbox"/> Hands | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Thighs inner/outer |
| <input type="checkbox"/> Feet | <input type="checkbox"/> Cellulite | <input type="checkbox"/> Face | <input type="checkbox"/> Legs | |

Hair Removal

Do you have unwanted hair on your body? No Yes (Where?) _____

	Yes	No	Date
Have you had hair removal by electrolysis?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laser (IPL, BBL, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Waxing?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Threading.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Means?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you use tanning beds? No Yes If yes, when was the last session? ___ / ___ / ___

Do you use self tanners or spray tan? No Yes If yes, when was last use? ___ / ___ / ___

When were you last exposed to the sun (tanning or working/playing outside)?..... ___ / ___ / ___

Do you have a vacation or sun exposure planned? No Yes If yes, when? ___ / ___ / ___

Do you have an upcoming event that you are planning for? No Yes ... If yes, when? ___ / ___ / ___

GOALS AND EXPECTATIONS

If there was something you could change or improve about your skin, what would it be?

Is there anything else you would like us to know before we start your treatment plan?

CLOVIS E MANLEY, MD LLC

4943 Rosebud Lane

Newburgh, IN 47630

PATIENT DEMOGRAPHIC FORM

Please present your driver's license or other photo ID, most recent insurance card(s) and copay if applicable.

Please PRINT

PATIENT INFORMATION

Last Name: First Name: MI:

Date of Birth: Social Security Number: Gender: Male Female

Address: City: State: Zip:

Cell Phone #: Home Phone #: Email Address:

Marital Status: Single Married Divorced Separated Widowed

Employment Status: Employed Full-Time Employed Part-Time Self Employed Not Employed Disabled Retired Active Duty Military

Employer Name: Phone #: Occupation:

EMERGENCY CONTACT

Name: Phone #: Relationship to Patient:

PRIMARY INSURANCE

Insurance Name: Policy/ID #: Effective Date:

Policy Holder's Relationship to Patient: Self Spouse Parent Other (specify):

Name of Policy Holder: DOB: SSN #:

Address (if different than the patient): Phone #:

SECONDARY INSURANCE (if applicable)

Insurance Name: Policy/ID #: Effective Date:

Policy Holder's Relationship to Patient: Self Spouse Parent Other (specify):

Name of Policy Holder: DOB: SSN #:

Address (if different than the patient): Phone #:

I certify the above information is correct to the best of my knowledge.

Signature: Date:

Verified Date/Initials

Clovis E. Manley, MD, LLC
4943 Rosebud Lane
Newburgh, IN 47630

Patient's Name _____ DOB _____ Date _____

AUTHORIZATIONS, ASSIGNMENT OF BENEFITS, FEES AND PRIVACY NOTICE

- 1. Treatment authorization.** I expressly authorize this practice to provide me with reasonable and proper care by the standard of care in the community.
- 2. Medicare lifetime signature on file (applies to Medicare patients only).** I request payment of authorized Medicare benefits be made to Clovis E. Manley, MD, LLC for any services furnished to me by this practice. I authorize any holder of medical information about me to release required information to the Center for Medicare and Medicaid Services (CMS) and its agents as needed to determine benefits and payment for benefits for services rendered. Our office accepts assignment on fees for our Medicare patients. We will submit your Medicare claims to CMS for you.
- 3. Assignment of benefits.** I request payment of authorized medical insurance benefits be made on my behalf to Clovis E. Manley, MD, LLC. I understand that the office does not accept all forms of insurance. I understand the office will file my insurance claim to accepted insurance plans as a courtesy to me. I am responsible for payment of co-pays, coinsurance, and deductibles for covered services. Services that are not covered by insurance are my responsibility and I agree to pay in full. I authorize the release of my medical information needed to process my insurance claims.
- 4. Non-acceptance of Medicaid.** I understand that Clovis E. Manley, MD LLC and its business entities do not accept Medicaid benefits or Medicaid-funded insurance plans. I understand that my medical claims will not be filed to Medicaid for processing.
- 5. Insurance cards.** I agree to inform the office of any changes in my insurance coverage in advance of obtaining any additional services. I will bring my insurance card to every visit.
- 6. Contact information.** I agree to inform the office of any changes in my contact information, including name, phone number, and mailing address.
- 7. Record copying fee.** I understand I have a right to the information in my medical records, but the original records belong to the practice. I understand it is expensive and time consuming to copy medical records. I understand that a reasonable copying fee will be charged anytime I request a copy of my records or transfer my records to another provider. However, **I will not be charged** for: (1) copies of recent lab/imaging tests, (2) records sent to a specialist that the office refers me to, or (3) a copy of my most recent office visit.
- 8. Missed appointment fee.** I understand my credit card will be placed on file to hold my appointment or procedure time. **My credit card will not be charged unless:** I no show or fail to cancel or reschedule within 24 hours. A missed appointment fee is \$50.00. A missed procedure fee is \$100.00.
- 9. Collection fees.** I agree that if any unpaid balance is assigned to a third-party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay any attorney fees or court costs incurred in the course of the collection of my fees. I agree to pay pre-judgment and/or post judgment interest on any overdue balance at the current legal rate.
- 10. Notice of AI-Assisted Documentation.** Clovis E. Manley, MD, LLC uses an AI-assisted clinical documentation tool ("AI scribe") to help create medical notes during some office visits. This technology processes spoken clinical conversations solely for documentation purposes and does not make medical decisions or replace your provider's judgment. All notes are reviewed, edited and finalized by your provider. Any protected health information is handled in compliance with HIPAA and the AI vendor operates as a HIPAA-compliant business associate of the practice. Audio is not used for marketing or AI training and is not retained beyond what is necessary to generate the note. Indiana law permits audio recording with the consent of at least one party. By continuing with a visit that uses AI scribing you acknowledge this use. If you prefer not to have AI-assisted documentation used during your visit, please inform the staff – your care will not be affected and an alternative documentation method will be used.
- 11. Privacy policy.** I received a copy of the Notice of Privacy Practices for Clovis E. Manley, MD, LLC.

Signature _____