421 N. Rodeo Dr.
Terrace Level, North (2nd Floor) T-7
Beverly Hills, CA 90210
310-274-5372

MOY :: FINCHER :: CHIPPS
FACIAL PLASTICS & DERMATOLOGY

Patient Information

Name: ____ ☐ Jr. ☐ Sr.
Last First Middle
Prefer to be called: ______________________ Title: ☐ Mr. ☐ Mrs. ☐ Miss

Date of Birth: ____/_____/_____ Age: ____ Sex: ☐ Male ☐Female Marital Status: _____________

Address: ____
Street Number Street Name City State Zip Code
Preferred? ☐ Home: _____________ ☐Cell: ______________ ☐ Work: ____________
Email: ______________________________ Social Security: _____-_____-______

Employer: ____
Name Address Phone
Occupation: ________________________Hobbies: _________________________

Who referred you: ___________________ Primary Care Physician: ________________________

Pharmacy of Choice: __________________________________ - _____________
Pharmacy Name Pharmacy Zip Code
Emergency Contact: ____________________________ Phone: ______________________
Do we have your permission to:
- ☐ Send you electronic communication
- ☐ Leave a message on your answering machine at home
- ☐ Leave your message at your place of employment
- ☐ Discuss your medical condition with any member of your household.

If yes, whom: ___________________________ Relationship: ______________________

Responsible Party/Parent (if different from patient)
Name: ____ ☐ Jr. ☐ Sr.
Last First Middle
Date of Birth: ____/_____/_______ Age: ____ Sex: ☐ M ☐ F Social Security: _____-____-____

Address: ____
Street Number Street Name City State Zip Code
Preferred? ☐Home Phone: ________ ☐Cell Phone: ______________ ☐ Work Phone: ____________
Reason for Visit.
Please describe what the problem is, where it is located, how it bothers you, when it first began, what is first looked like, what you think caused it, was a biopsy done, and any other treatments you have had so far.

____

____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician**. I also approve all the above information.**
Patient or Responsible Party Signature:

____ Date: ______________

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MEDICAL HISTORY

General Medical History:

Height: _____ Weight: ______

Check all that apply.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Migraines
- ☐ Organ Transplant
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ I am over 65 and have received the pneumonia vaccine since turning 65.
- ☐ I wear contacts, glasses, and/or dentures. Specify which: _______________
- ☐ None/Other:

____

Past Surgeries:

- ☐ Appendix: Appendectomy
- ☐ Bladder: Cystectomy
- ☐ Breast: Biopsy
- ☐ Breast: Implants
- ☐ Colon: Resection
- ☐ Cosmetic: Type _______
- ☐ Gallbladder: Cholecystectomy
- ☐ Heart: Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Transplant
- ☐ Heart: Pacemaker
- ☐ Joint Replacement: Hip
- ☐ Joint Replacement: Knee
- ☐ Kidney: Nephrectomy
- ☐ Liposuction
- ☐ Liver Transplant
- ☐ Liver Shunt
- ☐ Ovaries: Endometriosis
- ☐ Ovaries: Oophorectomy
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Cancer
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Spleen: Splenectomy
- ☐ Testicles: Orchiectomy
- ☐ Uterus: Hysterectomy
- ☐ None/Other:

____

Skin Type: If in the sun without sunscreen, would you:

- ☐ 1. Always burn, never tan
- ☐ 2. Always burn, sometimes tan
- ☐ 3: Sometimes burn, always tan gradually
- ☐ 4. Burn minimally, always tan well
- ☐ 5. Rarely burn, tan profusely
- ☐ 6. Never burn, deeply pigmented

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Skin History:

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Atypical Moles
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ None/Other:
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous Cell Skin Cancer
- ☐ I wear sunscreen. SPF: ___
- ☐ I tan in tanning salon

____

Family History: ☐ Melanoma ☐ Basal/Squamous Cell Carcinoma
If yes, which relative:
____

Social History:

- ☐ I am pregnant and/or breastfeeding
- ☐ I am contemplating pregnancy

Sexual History

- ☐ Not sexually active
- ☐ Active with one partner
- ☐ Sexually active with more than one partner
- ☐ Sexually active with same gender partner

Cigarette Smoking

- ☐ Never smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

Alcohol Use

- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks d day
- ☐ 3+ drinks a day

Safety

- ☐ Feel safe at home

Race:

- ☐ Asian
- ☐ Black/African American
- ☐ White
- ☐ Hispanic
- ☐ Native Hawaiian/Other Pacific
- ☐ Other:

Ethnicity:

- ☐ Hispanic or Latin American
- ☐ Non-Hispanic or Latin American
- ☐Prefer not to answer

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MEDICATION/ALLERGY LIST

Medications: ☐ No current medications

Name	Dosage	How Often

Allergies: ☐ No known/current allergies or medication sensitives

Medication/Food	Reaction

Photography Consent
I consent to and authorize Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., Lisa Chipps, M.D., or Lauren Moy M.D., and his/her associates to take photographs of parts of my body (and/or pathology images) in connection with the dermatologic procedures (surgical or non-surgical) performed by Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., Lisa Chipps, M.D., or Lauren Moy, M.D. and his/her associates.

I understand that such photographs are used by Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., Lisa Chipps, M.D., or Lauren Moy, M.D. and his/her associates to monitor the results of your treatment(s).
I understand that such photographs may be published by Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., Lisa Chipps, M.D., or Lauren Moy, M.D., and his/her associates in any print, visual, or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the public about dermatologic surgery methods.

This may include:

1. Patient Education- (showing patients my before and after photographs)
2. Advertisements- (showing before and after photographs)
3. Displays in the office- (showing before and after photographs)
4. Scientific/ Medical publications, presentations, and classes
5. Books, magazines, and other presentations

If there are any objections to any of the above items mentioned, please cross off the line and place your initials adjacent to the crossed off area.

Neither I, nor any member of my family will be identified by name in any publication. I understand that, although an attempt will be made to hide my identity, in some circumstances the photographs may portray features which could make my identity recognizable.

I release and discharge Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., Lisa Chipps, M.D., or Lauren Moy, M.D., and his/her associates, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature:
____ Date: ________________

MIPS Patient Intake Form

Patient Name: ________________________________ Date of Birth: ________________

Primary Care Provider: ________________________________ Referring Provider: ________________________________

Information for patients who are 12 and older

Do you currently use tobacco products? ☐Yes ☐No

Information for patients who are turning 13 in 2025

Have you had one dose of meningococcal vaccine on or between your 11th and 13th birthday? ☐Yes ☐No

Have you had one tetanus, diphtheria toxoids and acellular pertussis vaccine(Tdap) on or between your 10th and 13th birthday? ☐Yes ☐ No

Have you completed the HPV vaccine series on or between your 9th and 13th birthday? ☐Yes ☐No

If no to the above, reason: ____

Information for Patients who are 65 and older

Do you have an Advance Care Plan? ☐Yes ☐ No

If yes, please select the following that apply to your care plan:

☐ Full Code ☐ Do not intubate ☐ Do not resuscitate ☐ Living Will ☐ Health Care Proxy

If health care proxy, provide Name & Phone #: ____

Signature: ____________________________ Date: ________________