





### General Medical History:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Check all that apply.

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

### Past Surgeries:

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

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

- |  |   |
|--|---|
| <input type="checkbox"/> 1. Always burn, never tan               | <input type="checkbox"/> 4. Burn minimally, always tan well |
| <input type="checkbox"/> 2. Always burn, sometimes tan           | <input type="checkbox"/> 5. Rarely burn, tan profusely      |
| <input type="checkbox"/> 3. Sometimes burn, always tan gradually | <input type="checkbox"/> 6. Never burn, deeply pigmented    |

Continued





**Skin History:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Squamous Cell Skin Cancer    |
| <input type="checkbox"/> Actinic Keratoses      | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> I wear sunscreen. SPF: _____ |
| <input type="checkbox"/> Atypical Moles         | <input type="checkbox"/> Melanoma               | <input type="checkbox"/> I tan in tanning salon       |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Precancerous Moles     |   |
| <input type="checkbox"/> Blistering Sunburns    | <input type="checkbox"/> Psoriasis              |   |
| <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Rosacea                |   |
| <input type="checkbox"/> None/Other: _____      |   |   |

**Family History:**  Melanoma  Basal/Squamous Cell Carcinoma

If yes, which relative:

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**Social History:**

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

**Sexual History**

- Not sexually active
- Active with one partner
- 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



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 Fincher, M.D., Ph.D., Lisa Chipps, M.D., Lauren Moy, M.D. William Kwan 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 our licensed medical providers, and his/her associates.

I understand that such photographs are used by Edgar Fincher, M.D., Ph.D., Lisa Chipps, M.D., Lauren Moy M.D. and William Kwan M.D. his/her associates to monitor the results of your treatment(s).

I understand that such photographs may be published by our medical providers 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 Edgar Fincher, M.D., Ph.D., Lisa Chipps, M.D., Lauren Moy M.D., William Kwan 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: \_\_\_\_\_

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Terrace Level, North (2<sup>nd</sup> Floor) T-7  
Beverly Hills, CA 90210  
310-274-5372



MOY :: FINCHER :: CHIPPS  
FACIAL PLASTICS & DERMATOLOGY

As you know, if you have ever checked into a hotel or rented a car, the first thing you are required to do is to provide your credit card information which will be used to pay your bill. This is an advantage for both you and the business since it makes checkout easier, faster, and more efficient. We have implemented a similar policy. You will be required to provide your credit card at the time of your check in and the information will be held securely until your insurances have paid their portion and notified our office of your remaining deductible amount. At that time, any remaining unpaid balance is owed by you and your credit card will be charged for that remaining balance. A copy of the charge will be mailed to you. This service is an advantage to you since you will no longer have to write out a check and mail it into our office. This will help process your medical claims in a timely manner and help to keep the cost of health care expenses down. This service will not compromise your ability to dispute a charge nor question your insurance company's determination of payment. In addition, all Co-Pays Co- Insurances are due at the time of service will continue to be collected at the visit. If you have any questions, please call our office at: 310-274-5372. Sincerely, The Doctors of the Moy-Fincher-Chipps Medical Group an affiliate of Golden State Dermatology Authorization

To Charge Credit Card Patient Name: \_\_\_\_\_ MRN (for office use): \_\_\_\_\_

\_\_\_\_\_ I have read the above policy and authorize the Moy-Fincher-Chipps Medical Group to keep my signature on file and to charge my credit card for the outstanding balance to my account (deductibles, co-payments, and non-covered services) NOT paid by my insurance.

Credit card type: VISA MC AMEX Other: \_\_\_\_\_

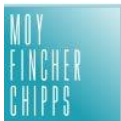
Credit Card Number: \_\_\_\_\_ 3-digit security code: \_\_\_\_\_

Printed Name on card: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**MIPS Patient Intake Form**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Dr./Provider name: \_\_\_\_\_

**Information for patients who are 12 and older:**

Do you currently use tobacco products? YES NO (circle one)

**Information for patients who are turning 13 in 2026:**

Have you had one dose of meningococcal vaccine on or between your 11<sup>th</sup> and 13<sup>th</sup> birthday? YES NO (circle one)

Have you had one tetanus toxoids and acellular pertussis vaccine (Tdap) on or between your 10<sup>th</sup> & 13<sup>th</sup> birthday? YES NO

Have you completed the HPV vaccine series on or between your 9<sup>th</sup> and 13<sup>th</sup> birthday? YES NO

If no to the above, reason: \_\_\_\_\_

**Information for Patients who are 65 and older:**

Do you have an Advanced Care Plan or a Surrogate Decision Maker (someone who can make medical decisions for you if you are not able to)?

YES NO (circle one)

If yes, please provide name & phone#: \_\_\_\_\_