Today's Date: _____

Name: _____ DOB: _____

Primary Care Physician / Contact: _____

Referring Physician (if different): _____

Birth Sex: ☐Male ☐Female Preferred gender: ☐Male ☐Female ☐Other:_____

Preferred language: _____ Race/Ethnicity: _____

Emergency contact name: _____ Phone number: _____

Relationship: _____

Preferred pharmacy (please include name, address, cross streets, or phone number):

_____

How did you hear about us? ☐**PCP** ☐**Friend** ☐**Insurance** ☐**Other**:_____

Reason for visit (*separate visit may be required):

☐Acne ☐Upper body skin exam/ Full body skin exam ☐Spot(s) of concern

☐Hair Loss* ☐Psoriasis ☐Rash* ☐Cosmetic concerns*

☐Other: _____

Skin Disease History: NONE☐

Check if applies

☐Acne ☐Actinic keratoses (pre-cancers) ☐Blistering sunburns

☐Eczema ☐Basal cell carcinoma ☐Seborrheic dermatitis

☐Psoriasis ☐Squamous cell carcinoma ☐Atypical/dysplastic moles

☐Psoriatic Arthritis ☐Melanoma

☐Allergic contact dermatitis (Cause?):_____

☐Other:_____

Do you wear sunscreen? **Yes**☐ **No**☐ SPF?_____

Have you ever used a tanning bed? **Yes**☐ **No**☐ Currently? **Yes**☐ **No**☐

Total number of lifetime tanning sessions: _____

Continued on next page

Name: _____ DOB: _____

Past Medical History: NONE☐
Check if applies

☐Atrial Fibrillation
☐Coronary Artery or Heart Disease
☐Heart attack or stents
☐High Blood Pressure
☐High Cholesterol
☐Asthma
☐COPD
☐Diabetes
☐End Stage Renal Disease
☐GERD (reflux / heart burn)
☐Anxiety
☐Depression
☐Bone Marrow Transplantation
☐Leukemia
☐Lymphoma
☐Glaucoma
☐Hearing Loss
☐Herpes or Cold Sores
☐HIV/AIDS
☐Seizures
☐Stroke
☐Anemia
☐Thyroid problems (hyper or hypothyroidism)
☐Arthritis (joint pain): Type: _____
☐Hepatitis: Type: _____ Treatment: _____
☐History of Tuberculosis
☐Solid Organ Transplantation: Organ: _____ Year: _____
☐Immunosuppression: _____
☐Cancer (other than skin): Type: _____ Year: _____
☐Lupus or other autoimmune disease: Type: _____

Past Surgical History: NONE ☐

Skin Cancer Surgery: _____

Cosmetic Procedures: _____

Joint Replacement: Joint: _____ Year: _____

Do you take antibiotics before going to the dentist? **Yes☐ No☐**

Cancer Surgery (other than skin): _____

Heart Surgery (including pacemaker or other implant): _____

Heart Valve Replacement: Valve: _____ Type: _____ Year: _____

Lung/Abdomen Surgery: _____

Other: _____

Continued on next page

Name: _____ DOB: _____

Family History (indicate relative & disease): NONE ☐

Melanoma: _____ Skin cancer (non-melanoma): _____

Psoriasis: _____ Other skin disease: _____

Social History:

Occupation: _____ Are you married? **Yes☐ No☐**

Are you sexually active? **Yes☐ No☐**

Do you currently use contraception? **Yes☐ No☐** If yes, type? _____

Women: Currently pregnant or trying? **Yes☐ No☐** Currently breastfeeding? **Yes☐ No☐**

Medications: Please list **each medication** (including over the counter and supplements) with **the dosage.** You may attach a pre-printed list if you prefer. **NONE ☐**

_____

_____

_____

_____

Allergies: NONE ☐

Medication Allergies: Please list **each medication** (including over the counter) and **the reaction**.

_____

_____

Seasonal or Environmental Allergies: **Yes☐ No☐** If yes, to what? _____

Are you currently experiencing any of the following?

☐Fever	☐Bleeding problems	☐Blood in urine
☐Chills	☐Easy Bruising	☐Blood in stool
☐Night Sweats	☐Joint Aches	☐Nausea / Vomiting
☐Unintentional weight loss	☐Sore throat	☐Abdominal cramps or pain
☐Headache	☐Cough	☐Blurry vision
☐Weakness	☐Chest Pain: Severity? _____	
☐Numbness	☐Shortness of breath: Severity? _____	

Continued on next page

Name: _____ DOB: _____

Smoking Status (Please choose one) Current every day smoker

☐Current someday smoker

☐Former smoker

☐Never Smoked

☐Unknown if smoked

Number of packs per day: ____

Number of years smoked: ____

Vaccinations:

Have you received a flu vaccination within the last year? **Yes**☐ **No**☐

If answered no, answer one of the following:

☐I am allergic to the vaccine

☐I do not want the flu shot

☐I have not received the flu shot because _____

If over the age of 65, have you **ever** received a pneumonia vaccine? **Yes**☐ **No**☐

Advanced Care Plan: **NONE**☐

Do you have any of the following?

☐Living Will (Care plan)

☐Do Not Resuscitate

☐Do Not Intubate

☐Full Cardiac Resuscitation

☐Medical Power of Attorney / Healthcare Proxy

Name: _____ Contact Number: _____

_____ _____

Signature of Patient or Patient's Legal Guardian **Print Name if Signed by Legal Guardian**

Name: _____ DOB: _____

CONTACT CONSENT

Email: _____

Cell Phone: _____

Home Phone: _____

☐ I authorized Specialists in Dermatology PLLC to send me appointment reminders

☐ I authorize Specialists in Dermatology PLLC to send me patient education material and specials

☐ I authorize Specialists in Dermatology PLLC to send me a survey about my experience

☐ I authorize Specialists in Dermatology PLLC to leave a voice mail with results

_____ _____

Signature of Patient or Patient's Legal Guardian **Print Name if Signed by Legal Guardian**

INSURANCE INFORMATION

Patient Information:

Name (Last, First, Middle) _____

Date of Birth: _____

Mailing address: _____

City, State, Zip Code: _____

☐ NO INSURANCE/OUT OF NET WORK, SELF PAY PATIENT

Primary insurance:

Name of the insurance company: _____

Name of insurance card holder if different than Patient's: _____
(The primary subscriber on the insurance policy could be different than Patient's)

Insurance Policy Number or member ID: _____

Group # or account number: _____

Secondary Insurance Information (if applicable): _____

Name of insurance company: _____

Name of insurance cardholder: _____

_____ _____

Signature of Patient or Patient's Legal Guardian **Print Name if Signed by Legal Guardian**