Patient Name: _____ Date of Birth: _____/_____/_____
Today's Date: _____/_____/_____

General Information

Name_____ Age _____ Date of Birth ____/____/_____
Last First M.I.

SS#_____-____-_____ Sex: M F Marital Status _____ Email _____

Mailing Address: _____

_____
City State Zip Code

Phone: Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name of Insured _____ Relationship to Patient _____
Last First M.I.
SS#_____-____-_____ Date of Birth (of insured) _____/_____/_____

Mailing Address:_____
City State Zip Code
Phone: Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____ Policy Holder's Name _____
SS#_____-_____-_____ Date of Birth _____/_____/_____

Group # _____ Contract # _____

Employer Name: _____Employer Phone #: _____

Relationship of patient to the Insured _____ **Do you have secondary Insurance? _____

In case of Emergency, who should be notified (other than those already listed above)?

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

All of the above is correct to the best of my knowledge, and I agree to notify this office in a timely manner of any changes.
Patient or Responsible Party Signature _____ Date _____/_____/20_____

Patient Name: _____ Date of Birth: _____/_____/_____
Today's Date: _____/_____/_____

REASON FOR TODAY'S VISIT: _____

Past Medical History: (please circle all that apply) ***must** circle "None" if none apply

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH (Prostate Enlargement)
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (reflux)
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
NONE
Stroke
Thyroid Problems
- Hyperthyroidism
- Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures

OTHER:

Past Surgeries: NO PRIOR SURGERIES

_____
_____
_____

Skin Disease History: (please circle all that apply) ***must** circle "None" if none apply*

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
NONE

OTHER:

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No (If "yes", who? _____)

Medications: (Please list all current medications including over the counter) NO MEDICATIONS

_____
_____
_____
_____

Allergies: (Please list all allergies) NO ALLERGIES

_____
_____

Patient Name: _____ Date of Birth: _____/_____/_____
Today's Date: _____/_____/_____

REQUIRED QUESTIONS (these are required by government for all patients)
Preferred Language: _____ Race: _____

Ethnic Group: (please circle which applies to you)

Decline to specify	Not Hispanic or Latino
Hispanic or Latino	Unknown

Smoking Status:

Unknown	Former Smoker
Current everyday smoker	Never smoker
Current someday smoker (tobacco, cigarette)	Smoker, current status unknown

Alcohol Use:

None	1-2 drinks per day
Less than 1 drink per day	3 or more drinks per day

Family History (Only first degree relatives): (please circle all that apply)

	YES	NO	RELATIVE	COMMENTS
Melanoma				
Skin Cancer (non-melanoma)				
Psoriasis				
Thyroid Disease				
Autoimmune Disease				
Depression				
Diabetes				
Hair Loss (Alopecia)				
Lupus				
Unknown				

ALERTS: (please circle all that apply)

Allergy to adhesive	Blood thinners
Allergy to lidocaine or other anesthetics	Defibrillator or Pacemaker
Allergy to topical antibiotics	History of MRSA
Allergy to latex	Require antibiotics prior to a surgical procedure
Artificial heart valve	Rapid heart beat with epinephrine
Artificial joint replacement	

Patient Name: _____ Date of Birth: _____/_____/_____
Today's Date: _____/_____/_____

Preferred Pharmacy Name: _____
Pharmacy City: _____ *Pharmacy Zip Code: _____ **(required)**
Pharmacy Phone#: _____

Emergency Contact:
Name: _____Phone Number: _____
Spouse: _____Phone Number: _____

Preferred phone to contact you? _____home _____ work _____ mobile
Is it okay to leave a detailed message? _____ yes _____ no

Occupation: _____
Primary Care Physician: _____ Referring Physician: _____

Review of Symptoms: Are you **currently** experiencing any of the following? (Please circle all that apply)

NO to all of the below	Nausea/vomiting	Hay fever
Fever or chills	Dry skin	Chest pain
Cough	Unintentional weight loss	Thyroid problems
Night sweats	Abdominal pain	Sore throat
Headaches	New lumps or bumps	Bloody stool
Blurry vision	Problems with healing	Bloody urine
Joint aches	Rash	Muscle weakness
Depression	Fatigue	Neck stiffness
Suicidal thoughts	Easy bruising	Seizures
Photosensitivity	Problems with bleeding	Shortness of breath
Dry eyes	Problems with scarring	Wheezing
Dry lips	Immunosuppression	Anxiety

Other pertinent symptoms: _____

FEMALES ONLY: circle ALL that apply

PREGNANT	Birth Control Pills
NURSING	IUD
Hysterectomy	PLANNING PREGNANCY in next 6-12 months
Tubal ligation	Other contraception:
Ablation	