DERMATOLOGY ASSOCIATES
Dermatology and Dermatologic Surgery

PATIENT INFORMATION

Name: ____
Last *First* *M.I.*

Date of Birth: ___ / ___ / ___ Age: _____ Sex: Male / Female SSN: ______________

Mailing Address: ____
City *State* *Zip*

Phone: ( ) ______________ Email Address: ______________

Employer: ______________ Occupation: ______________

Referring Physician: ______________ Preferred Pharmacy: ______________

May we leave personal medical information on your answering machine or cell phone? ❑ YES ❑ NO

Do you have a Health Care Proxy ❑ YES ❑ NO If yes, please provide name and number.

Proxy Name: ______________ Proxy Phone: ( ) ______________

RESPONSIBLE PARTY (if different from patient)

Name: ______________________________ Date of Birth: ___ / ___ / ___
Last *First* *M.I.*

Address: ____
City *State* *Zip*

Phone: ( ) ______________

PAYMENT POLICY

The Adult/Guardian who brings in a child will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

EMERGENCY CONTACT INFORMATION

In case of Emergency, whom should we notify?: ______________

Relationship: ______________ Phone: ( ) ______________

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: ______________ Relationship: ______________

Phone: ( ) ______________

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature: ______________________ Date: ___ / ___ / ___

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HISTORY AND INTAKE FORM

Name: ______________________________ Date of Birth: ________ Today's Date: ________

Past Medical History: (please check all that apply)

__ Anemia
__ Anxiety
__ Arthritis
__ Asthma
__ Atrial fibrillation
__ Bone Marrow Transplantation
__ Bleeding Disorder
__ Blood Clots
__ Cancer, Type: ______________
__ Cataracts
__ COPD
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ End Stage Renal Disease
__ GERD
__ Glaucoma
__ Hepatitis
__ High Blood Pressure
__ HIV/AIDS
__ High Cholesterol
__ Hyper or Hypo Thyroid
__ Leukemia
__ Lupus
__ Lymphoma
__ Radiation Treatment
__ Seizures
__ Stroke
__ Tuberculosis (TB)

Other: ____

____

Past Surgical History: (please check all that apply)

__ Colectomy
__ Coronary Artery
__ Mechanical Valve
__ Kidney Transplant
__ Biological Valve Replacement
__ Defibrillator
__ Heart Transplant
__ Joint Replacement within last 2 years
❑ Knee L / R
❑ Shoulder L / R
❑ Hip L / R
__ Hysterectomy
__ Liver Transplant
__ Pacemaker

Other: ____

Skin Disease History: (please check all that apply)

__ Acne
__ Actinic Keratoses
__ Psoriasis
__ Eczema
__ Flaking or Itchy Scalp
__ Dermatitis
__ Herpes Simplex (Cold Sores)
__ Melanoma
__ Basal Cell Skin Cancer
__ Squamous Cell Skin Cancer
__ Shingles
__ Scarring/Keloids
__ Rosacea

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, which relative?: ______________________________

Do you have a family history of Non-Melanoma? ❑ Yes ❑ No

If yes, which relative?: ______________________________

Name: ______________________ Date of Birth: ________ Today's Date: __________

Medications: (Please enter all current medications)

____

____

____

____

❑ Females only: Are you currently taking Birth Control? ❑ Yes ❑ No

If so, which kind?: ______________________________

Allergies including Non-Medication: (Please list all dye, tape or food allergies)

____

____

Allergy to Latex: ❑ Yes ❑ No

Social History: (Please check all that apply)

Cigarette Smoking (Cigarettes E-vape, Chew, etc.)

❑ Never Smoked ❑ Currently Smokes ❑ Has smoked in the past ❑ Former smoker

Alcohol Use (Beer, Wine, Hard Liquor, etc.):

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

Family History: (Please check all that apply)

__ Asthma

__ Cancer

__ Diabetes

__ Eczema

__ High Blood Pressure

__ Lung Disease

__ Psoriasis

__ Other: ______________________________

____

Preferred pharmacy and location: ______________________________