Dermatology and Skin Cancer Consultants, PLLC
Patient Registration Form 06/17/2016

Patient Name: ❑ Mr. ❑ Mrs. ❑ Miss. ❑ Ms. ❑ Dr.

First: _____ Middle: _____ Last: _____

Address: _____ City: _____ Zip Code: _____

Social Security#: ____-____-____ ❑ Single ❑ Married ❑ Other: _____

Date of Birth ____/____/____ Gender: ❑Male ❑Female Phone #: (____) _____

Work #: (____) _____ Cell #: (____) _____ Email: _____

We will email ***requested* records to your email address per the HIPAA Omnibus Rule, but please be advised that there is a risk of unencrypted emails being an unsecure method of exchange.**

Emergency Contact: Name:_____ Relationship:_____

PH#: (____) _____ Cell# or Work#: (____) _____

Pharmacy: _____ Street: _____ City: _____

****Social Security Numbers are required for lab work and in tracking insurance payments.****

Primary Insured (Responsible Party) Employment: ❑Full Time ❑Part Time ❑Retired ❑Other

Name (if other than patient): _____

Occupation: _____ Company: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

SSN: ____-____-____ Birthdate ____/____/____ Relationship to patient _____

If you were referred by a Doctor please provide their information below:

First: _____ Middle: _____ Last: _____

City: _____ State: _____ Phone #: (____) _____

Who is your Primary Care Doctor?

First: _____ Middle: _____ Last: _____

City: _____ State: _____ Phone #: (____) _____

****To request medical records from another doctor, please ask the nurse to sign a records release form.****

I have read the Financial Policy provided to me on a separate sheet by Dermatology & Skin Cancer Consultants, LLC and agree to abide by the terms that it sets forth.

Patient (or Guardian) Signature: _____ Date: _____

Dermatology and Skin Cancer Consultants, PLLC
MEDICAL HISTORY FORM 04/28/2016

What is the Reason for your Visit? _____

Please check below in order to receive test results*

I GIVE DERMATOLOGY AND SKIN CANCER CONSULTANTS, PLLC PERMISSION TO .....

	TEST RESULTS	GENERAL MEDICAL ISSUES
LEAVE MESSAGE ON CELL PHONE	❑	❑
LEAVE MESSAGE ON HOME PHONE	❑	❑
LEAVE MESSAGE WITH SPOUSE	❑	❑
SEND ME TEXTS	❑	❑
SEND ME EMAILS	❑	❑

DRUG ALLERGIES

❑ No Known Drug Allergies

ALLERGIES	
1.	**3.**
2.	**4.**

MEDICATIONS

❑ No Medications ❑ Medications Unknown

CURRENT MEDICATIONS	DOSE (mg)	FREQUENCY	PRESCRIBED BY

❑ *Additional Medications* ***(check here and list on back or have receptionist make copy of list)***

REVIEW OF SYSTEMS (Please check all <u>Current</u> Symptoms)

SKIN

BLEEDING MOLE ❑ No ❑ Yes CHANGING MOLE ❑ No ❑ Yes THINNING HAIR ❑ No ❑ Yes
DRY SKIN ❑ No ❑ Yes NAIL CHANGES ❑ No ❑ Yes
SKIN RASH ❑ No ❑ Yes SUN SENSITIVITY ❑ No ❑ Yes
Additional Notes: _____

ALLERGIC/IMMUNOLOGIC

JOINT PAIN ❑ No ❑ Yes DRY EYES/MOUTH ❑ No ❑ Yes
Additional Notes: _____

CONSTITUTIONAL SYMPTOMS

DIZZINESS ❑ No ❑ Yes NAUSEA/VOMITING ❑ No ❑ Yes
FEVER OR CHILLS ❑ No ❑ Yes UNEXPECTED WEIGHT LOSS/GAIN ❑ No ❑ Yes
Additional Notes: _____

Additional Notes: _____ **Patient Weight:** _____

PAST MEDICAL HISTORY (Please List All Medical Conditions Below)

_____

_____

PAST SURGERIES

OPERATION	DATE	NOTES

SKIN CANCER HISTORY

❑ MELANOMA ❑ OTHER SKIN CANCER Comments: _____

FAMILY HISTORY

		Afflicted Family Member	Comments
NO RELEVANT FAMILY HISTORY	❑		
AUTOIMMUNE DISORDERS	❑		
COLON CANCER	❑		
DIABETES	❑		
THYROID DISEASE	❑		
HIGH BLOOD PRESSURE	❑		
LIVER DISEASE	❑		
LUNG DISEASE	❑		
SKIN CANCER	❑		
MELANOMA	❑		

ALCOHOL & DRUG USAGE

❑ I DO NOT DRINK ❑ OCCASIONAL/SOCIAL (1-2 DRINKS) ❑ DAILY (1-2 DRINKS) ❑ DAILY (3+ MORE DRINKS)
❑ I DO NOT USE DRUGS ❑ I DO USE DRUGS; DRUG TYPES: _____

SMOKING STATUS

CURRENT EVERY DAY SMOKER ❑	CURRENT SOME DAY SMOKER ❑	FORMER SMOKER ❑
NEVER SMOKER ❑	HEAVY TOBACCO SMOKER ❑	LIGHT TOBACCO SMOKER ❑

Smoking Dates: Began _____ Stopped _____

PATIENT VERIFICATION OF MEDICAL HISTORY (Please Check One)

- ❑ I COMPLETED MY ABOVE MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE.
- ❑ AS A PARENT/GUARDIAN OF THIS PATIENT, I COMPLETED AND VERIFIED THE ABOVE MEDICAL HISTORY AS TRUE AND ACCURATE TO THE BEST OF KNOWLEDGE.
- ❑ MEDICAL HISTORY OBTAINED BY DERMATOLOGY AND SKIN CANCER CONSULTANTS STAFF.

*****All biopsy specimens are sent for analysis to a Dermatopathologist. You will get a separate bill from the Pathology lab.**

Patient/Guardian Signature: _____ Date: _____