DERMATOLOGY & SKIN SURGERY

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New Patient Form

Please complete the form below and bring to your visit.

Appointment Date: _____/_____/_____

Patient Name: _____ **Date of Birth:** _____/_____/_____

Social Security # __ __ __ -__ __- __ __ __ __ **Age**: _____ **Gender:** ☐ M ☐F

Home Phone: (__ __ __)__ __ __ - __ __ __ __ **Cell Phone:** (__ __ __)__ __ __ - __ __ __ __

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Widowed

HEALTHCARE TEAM

Referring Provider: _____ **Primary Care Provider:** _____

REASON FOR TODAY'S VISIT

Reason for Visit: _____

When the symptoms began (approximate): _____

Location: ☐ Arms ☐ Back ☐ Legs ☐ Head/neck ☐ Chest/abdomen ☐ Genitals

Symptoms: ☐ Itching ☐ Bleeding ☐ Pain ☐ Other: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe

What other signs and symptoms are you experiencing? *Check all that apply:*

☐ Bleeding ☐ Cracking ☐ Crusting ☐ Dry Skin ☐ Itching ☐ Oozing ☐ Pain ☐ Rash ☐ Other: _____

Have you seen any other physicians about this problem? ☐ No ☐ Yes, whom? _____

Have you had any previous treatment for your current condition? ☐ No ☐ Yes, please list: _____

_____

What have you used that makes it better/worse? (Medicines or over-the-counter products): _____

_____

ALLERGIES TO MEDICATIONS

☐ No Known Allergies ☐ Yes, *list all allergies and/or intolerances to medications & indicate reaction*

Medication Allergy	Reaction(s)
	☐ Rash ☐ Nausea ☐ Unknown ☐ Other: _____
	☐ Rash ☐ Nausea ☐ Unknown ☐ Other: _____
	☐ Rash ☐ Nausea ☐ Unknown ☐ Other: _____

MEDICATIONS/VITAMINS/SUPPLEMENTS

☐ Not taking any medications ☐ Taking medications, *list all medications, vitamins & supplements including dose*

	Medication	Dose (strength & quantity)	Prescribing Doctor
1.			
2.			
3.			
4.			
5.			
6			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

Continue on back page if needed….

REVIEW OF SYSTESM

Do you currently suffer from any of the following problems? Check no or yes.

Constitutional			Neurological/Psychiatric			Genitourinary			Metabolic/Endocrine		
No	**Yes**		**No**	**Yes**		**No**	**Yes**		**No**	**Yes**	
		Fatigue or tired			Depressed mood			Change in bladder			Cold intolerance
		Fever			Dizziness						Heat intolerance
		Weight gain			Headache			**Gastrointestinal**			Hair loss
		Weight loss			Paresthesia	**No**	**Yes**				
		Increased energy			Stress			Change in bowl habits			**Musculoskeletal**
		Decreased energy						Constipation	**No**	**Yes**	
								Diarrhea			Bone pain
Integumentary			**HEENT**					Nausea			Joint aches/ pain
No	**Yes**		**No**	**Yes**							
		Bruising			Nose bleeds			**Reproductive**			**Hematologic**
		Chapped lips			Visual changes	**No**	**Yes**	--- *Women Only* ---	**No**	**Yes**	
		Itching/pruritus			Stomatitis (thrush)			Abnormal menses			Easy bleeding
		Photosensitivity						Yeast infections			Easy bruising
		Pigment changes	**Cardiovascular**					Nursing			
		Rash	**No**	**Yes**				Currently pregnant			
		Scarring tendency			Chest pain						
		Thinning hair									
		Skin changes (Discoloration)									

MEDICAL HISTORY

Place a Check in the box next to the following conditions you have been diagnosed with:

☐ Anemia	☐ Diabetes Type ___	☐ Hyperlipidemia	☐ Lupus
☐ Anxiety	☐ Glaucoma	☐ Hypertension	☐ Bone Marrow Transplant
☐ Blood Clots	☐ HIV/AIDS	☐ Kidney Disease	☐ Thyroid Disorder
☐ Depression	☐ Hepatitis C	☐ Liver Disease	☐ Tuberculosis (TB)
☐ Thick Scars	☐ Heart Disease	☐ Bleeding Problems	☐ Stomach Ulcers

☐ Skin Cancers – Specify: _____

☐ Skin Cancers - Specify: _____

FAMILY HISTORY

Circle the letter that represents the family member: Mother (M), Father (F), Sister (S) and Brother (B)

☐ Adopted

Father: ☐ Alive & Well ☐ Deceased, Cause of Death:_____ Age:_____

Mother: ☐ Alive & Well ☐ Deceased, Cause of Death:_____ Age:_____

Abnormal Moles	M	F	S	B	Dermatitis	M	F	S	B	Hypertension	M	F	S	B
Acne	M	F	S	B	Depression	M	F	S	B	Malignant Melanoma	M	F	S	B
Allergies	M	F	S	B	Diabetes type:___	M	F	S	B	Psoriasis	M	F	S	B
Asthma	M	F	S	B	Eczema	M	F	S	B	Rosacea	M	F	S	B
Basal Cell Carcinoma	M	F	S	B	Hepatitis	M	F	S	B	Squamous Cell Carcinoma	M	F	S	B
Cancer: _____	M	F	S	B	Hyperlipidemia	M	F	S	B	Other:_____	M	F	S	B

SOCIAL HISTORY

Tobacco Do you use tobacco? ☐ No/Never ☐ Yes ☐ Former - How long ago? _____ Age Quit:_____

Type/Status: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew ☐ Snuff ☐ Vape ☐ Other:_____

How may packs per day? ____ How many years? ____

Caffeine Do you drink caffeinated beverages ☐ No ☐ Yes, what type: _____ Cups per day:_____

Alcohol Do you drink alcohol? ☐ No ☐ Yes

Tanning Do you Tan: ☐ No ☐ Yes, how often:_____ ☐ Tanning bed ☐ Outside

Do you use sunscreen? ☐ No ☐ Yes

INSURANCE NOTICE:

Medicare or your insurance may only pay for services determined to be 'reasonable and necessary' (as defined in section 1862 of the Medicare Law). If Medicare or your insurance company determines that a particular service is not 'reasonable and necessary' under their program standards, Medicare or your insurance company may deny payment for that service.

Depending on your particular insurance, **you may need to have a written referral from your physician**. If this is true of your insurance, PLEASE BE ADVISED that the doctors are limited to performing or treating the specific services outlined on the referral written by your primary care physician. You should also be aware that **some insurance plans require that treatment procedures be done on a separate day following the evaluation of the problem**. I have read and understand the Insurance Notice and do accept responsibility for payment should my insurance at any time deny payment.

Patient or responsible party**:** _____ **Date:** _____/_____/_____

(Signature)

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other: _____