PATIENT INFORMATION

*Required

*PATIENT NAME:_____
LAST FIRST MIDDLE

*ADDRESS:_____
STREET APT CITY STATE ZIP CODE

* CELL PHONE #:(_____)_____-_____ WORK PHONE #:(_____)_____-_____ HOME PHONE #:(_____)_____-_____

* PREFERRED CONTACT NUMBER: **HOME**_____ **CELL**_____**WORK**_____

***DATE OF BIRTH**: _____/_____/_____ ***SEX**: FEMALE MALE

EMAIL ADDRESS FOR **APPOINTMENT REMINDERS**:_____

SOURCE OF REFERRAL- PHYSICIAN NAME_____

OTHER (PLEASE SPECIFY)_____

RESPONSIBLE PARTY INFORMATION (WHERE TO SEND BILL)

RESPONSIBLE PARTY NAME: _____ ☐ SAME AS ABOVE
LAST FIRST MIDDLE

ADDRESS:_____
STREET APT CITY STATE ZIP CODE

*DATE OF BIRTH:_____/_____/_____ SEX: FEMALE MALE

HOME PHONE #:(_____)_____-_____ WORK PHONE #:(_____)_____-_____CELL PHONE #:(_____)_____-_____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:
COMPANY:_____ PHONE #:_____ CITY: _____

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

INSURANCE INFORMATION

****It is our policy that we have an updated copy of your insurance card for you to be seen****

INSURANCE COMPANY:_____

SUBSCRIBER'S NAME (POLICY HOLDER): _____ SUBSCRIBER'S DATE OF BIRTH: _____/_____/_____
(IF DIFFERENT FROM RESPONSIBLE PARTY INFORMATION)

☐ THE SUBSCRIBER IS THE SAME AS THE RESPONSIBLE PARTY

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

NAME: _____

Do you currently have any of the following?

YES / NO

- ___/___ Changing Moles
- ___/___ Blisters
- ___/___ Rash
- ___/___ Fever
- ___/___ Fatigue
- ___/___ Headache
- ___/___ Joint aches/pain
- ___/___ Muscle aching
- ___/___ Nausea
- ___/___ Vomiting
- ___/___ Diarrhea
- ___/___ Abdominal pain
- ___/___ Cough
- ___/___ Congestion
- ___/___ Unintentional weight loss
- ___/___ Blood in urine
- ___/___ Blood in stool

Do any of the following apply to you?

YES/NO

- ___/___ Asthma (now or ever)
- ___/___ Childhood eczema
- ___/___ Seasonal allergies/hay fever
- ___/___ GI Upset with antibiotics
- ___/___ Yeast infections with antibiotics
- ___/___ Hepatitis (now or ever)
- ___/___ Pregnant or planning pregnancy soon
- ___/___ Taking blood thinners (Coumadin, Plavix, Aspirin)
- ___/___ Depression
- ___/___ Seizure history
- ___/___ Started ANY new medications (RX or OTC) in the past 2 months

*If you have a medication list with you, please give it to the front desk staff.

PATIENT'S NAME _____
Primary Physician _____ Physician's Clinic_____
Pharmacy _____ City _____ Street _____

All MEDICAL CONDITIONS YOU HAVE BEEN TREATED FOR:

___ Arthritis
___ Asthma
___ Diabetes
___ High Blood Pressure
___ Elevated Blood Fats/Cholesterol or Triglycerides
___ Cancer
___ Other(s):_____ _____
_____ _____

LIST ALL MAJOR SURGERIES YOU HAVE HAD: __ NONE (No Surgeries)

___ Cancer Surgery: Type _____
___ Coronary Bypass
___ Joint Replacement
___ Organ Transplant
___ Heart Valve Replacement
___ Other(s) _____
_____

CHECK ANY MEDICATIONS THAT YOU ARE TAKING REGULARLY:

MEDICATION	DOSAGE	MEDICATION	DOSAGE	MEDICATION	DOSAGE
___ Atorvastatin/Lipitor	_____	___ Ibuprofen/Advil	_____	____ Others (please list)	
___ Birth Control Pill	_____	___ Insulin	_____	_____	_____
___ Citalopram	_____	___ Levothyroxine	_____	_____	_____
___ Enbrel	_____	___ Lisinopril	_____	_____	_____
___ Furosemide	_____	___ Metformin	_____	_____	_____
___ Humira	_____	___ Methotrexate	_____	_____	_____
___ Hydrochlorothiazide	_____	___ Prednisone	_____	_____	_____

___ I am currently NOT taking any medications.

ARE YOU TAKING ANY OF THE FOLLOWING BLOOD THINNERS?

___ Aspirin (dosage) _____
___ Plavix/Clopidogrel (dosage) _____
___ Coumadin/Warfarin (dosage) _____

MEDICATION ALLERGIES:

___Penicillin(s) ___Sulfa ___Others (please list) _____
_____

___ I have NO KNOWN Medication Allergies

IS THERE A FAMILY HISTORY OF MALIGNANT MELANOMA? ___ Yes ___ No
WHICH FAMILY MEMBERS: __ Mother __ Father __ Sister __ Brother __ Grandfather __Grandmother

SMOKING STATUS: ___Never ___ Former ___ Current

EMERGENCY CONTACT: NAME_____ Phone Number: _____

Can we leave a detailed message on your voicemail?
___Yes ___No