Desert Dermatology

New Patient Paperwork

Patient Information

PLEASE PROVIDE FULL LEGAL NAME FOR INSURANCE AND PRESCRIPTION PURPOSES

Patient Name:_____ Date Of Birth:_____ Age:_____

Birth Sex: Male ____ Female_____

Marital Status: Single Married Divorced Separated Widowed

Preferred Language:_____ Race:_____

Email Address:_____

Home Phone: _____ Mobile Phone: _____Work Phone:_____

Is it OK to leave a detailed message: Yes No

Emergency Contact
Name:_____ Phone Number:_____ Relationship:_____

Billing Address
Street:_____ City:_____

State:_____ Zip Code:_____

Seasonal Address (if applicable):
Street:_____City:_____

State:_____ Zip Code:_____

Patient Medical Insurance

Primary Insurance:_____

ID Number / Policy Number:_____ Group Number: _____

Policy Holder :_____ Relationship to Patient _____

Policy Holder D.O.B:_____

Continue on Back Side

Scondary Insurance:_____

ID Number / Policy Number:_____ Group Number: _____

Policy Holder :_____ Relationship to Patient _____

Policy Holder D.O.B:_____

Pharmacy Information

Provide as much information as possible to ensure prescriptions are sent to the correct pharmacy

Pharmacy Name:_____

Pharmacy Address: _____

Current Medications

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Do you have any medication allergies? ☐ No ☐ Yes If Yes, please list below

_____

Current & Past Medical History

Please circle yes or no

Latex Allergy	Y / N	Bleeding Disorders	Y / N	Poor Wound Healing	Y / N
Lupus	Y / N	Adhesive Allergy	Y / N	Heart Disease	Y / N
Arthritis	Y / N	Blood Thinners	Y / N	Kidney Disease	Y / N
Psoriasis	Y / N	Depression	Y / N	Thyroid Disease	Y / N
Hepatitis	Y / N	Artificial Heart Valves	Y / N	Hypertension	Y / N
MRSA	Y / N	Pacemaker/ Defibrillator	Y / N	High Cholesterol	Y / N
Diabetes	Y / N	Mitral Valve Prolapse	Y / N	Pre-Dental Antibiotics	Y / N
Type_____		Immunosuppressed	Y / N	Epinephrine Allergy	Y / N
Asthma	Y / N	Organ Transplant	Y / N	Neosporin Allergy	Y / N
HIV Positive	Y / N	CCL Chronic Leukemia	Y / N	Artificial Joints	Y / N
HSV / Cold Sores	Y / N	Memory Problems	Y / N	Pre-Op Antibiotics	Y / N
Hay Fever	Y / N	Fainting / Syncope	Y / N	Abnormal Scars	Y / N
				Anxiety	Y / N

Other:_____

Skin Cancer History

Do you have a history of skin cancer(s)? ☐ No ☐ Yes

If Yes, what type(s) _____

Do you have a history of Melanoma? ☐ No ☐ Yes

Do you have a **family history** of Melanoma? ☐ No ☐ Yes

Do you have a **family history** of other cancer(s) ☐ No ☐ Yes

If Yes, what type(s)_____

Social History

Please answer honestly as if can affect your treatment

What is your smoking status ?

Do you consume alcohol? ☐ No ☐ Yes

How many times in the past year have you had 4 or more drinks in a day?_____

Do you use any Recreational Drugs? ☐ No ☐ Yes

If yes, Which ones?_____

Do you use Sunscreen? ☐ No ☐ Yes

If yes, what is the SPF?_____

Tanning Bed Usage ☐ Never ☐ Currently Using ☐ Previously Used

Women's Only History

Are you Pregnant? ☐ No ☐ Yes Are you Breastfeeding? ☐ No ☐ Yes

Are you on birth control? ☐ No ☐ Yes Do you have regular menstrual cycles? ☐ No ☐ Yes

Height_____ ***Weight***_____

Referring Physician:_____ ***Primary Care Physician***_____

Release of PHI

Protected Health Information

Name:_____ D.O.B:_____ Relationship:_____
Name:_____ D.O.B:_____ Relationship:_____
Name:_____ D.O.B:_____ Relationship:_____

All waivers and consents are to be signed on the IPad, Please contact someone at the front desk to do so.