New Patient Q

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Patient Information as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (enter today’s date)

(Please Print Legibly & Fill In or Correct All Fields)

# Patient’s Name

Contact Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last

First

Middle

Address

Street & Apt #

City

State

Zip

Home Phone

Cell Phone

Other Phone

Any restrictions for contacting you?



 No



 Yes

E-mail

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Age Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_

Marital Status  Single  Married to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Name & Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Emergency Contact

 Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you give us permission to contact the above listed Emergency Contact to discuss your general medical information (i.e. diagnosis, treatments, payments, etc.)? Yes No

Can confidential health information about you (i.e. appointment reminders, pathology/lab results, etc) be left on your answering machine or voicemail? Yes No

**How did you hear about us?**

 Newspaper ad  Word of mouth  Referred by current TDI patient  Referred by my doctor

I understand that office visit charges are payable on the day service is rendered. I authorize The Dermatology Institute to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between The Dermatology Institute and myself.
I also understand that TDI’s Notice of Privacy Practices and Messaging/Website Privacy Policy are posted in the waiting area and on the TDI website, and that a physical copy may be made available to me upon request.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intake

and

History

Form

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_


# Past Medical History

**Select any of the following medical conditions you currently have:**Autoimmune disease (i.e. lupus, rheumatoid arthritis, type I diabetes, vitiligo, thyroid disease, etc)
History of Internal Cancer (i.e. colon, uterine, breast, lung, lymphoma, etc)
 If so, which cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was it diagnosed/treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Type 2 Diabetes
Joint surgery If so, which joint and when operated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
History of Heart disease, stroke, or clotting disorder
 If so, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
HIV/AIDS
Organ transplant If so, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Past Surgical History

**Please list any major surgeries you have had in the past 3 years:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Skin Disease History

 **Select any of the following medical conditions you currently have:**History of Skin Cancer (i.e. basal cell carcinoma, squamous cell carcinoma, melanoma, etc)
 If so, which cancer? BCC SCC Melanoma When was it diagnosed/treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Family History of Melanoma Which relative? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Eczema/Atopic Dermatitis
Acne/rosacea

# Allergies

**List all allergies and reactions if known:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Immunizations

**Have you received any of the following immunizations?**

 Influenza vaccine?: Yes No Pneumonia vaccine? Yes No

# MedicationsList all current medications:

 Medication name Dose (i.e. 10mg) Frequency (i.e. two pills twice a day)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History**

**Smoking Status (please choose one):**Never smoker Former Smoker Current smoker

**Alcohol Intake (please choose one):**None 1 or less per day 1-2 per day 3 or more per day

 **Review of Systems
Please check yes or no if you CURRENTLY have any of the following:**Problems with healing Problems with scarring (i.e. keloid) Problems with bleeding
Fever/chills Current use of blood thinners Artificial joints in the past 2 years
Defibrillator Pacemaker Artificial heart valve Allergy to lidocaine Allergy to adhesive

# Reason for Visit Today

**What brings you here today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long ago did you notice this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle any of the following that pertain to your concern today:**Itchy Bleeding Changing color Changing size Painful Red Scaly Looks different

**Have you tried treating with any prescription or over-the-counter medications?** Yes No
 If so, which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Surgical Procedure Consent Form

During your clinic visits with us, it may be necessary for your dermatology provider to perform various surgical procedures for diagnostic and/or treatment purposes, including but not limited to biopsies, cryosurgery ("freezing"), excision, etc. The reason for the procedure(s), as well as any risks, benefits, and alternatives of the procedure(s) will be discussed with you during your visit. However, we have listed the most common of these risks as follows: scarring, atrophy, recurrence, bleeding, hematoma, seroma, dyspigmentation, redness, pain/discomfort, infection, cosmetic disfigurement, nerve damage or numbness, and loss of function, anesthesia allergy and/or anaphylaxis. You are encouraged to ask your dermatology provider any questions or concerns that you may have prior to the procedure. By signing below, you acknowledge: your understanding of these potential risks, your consent for such dermatologic procedures to be performed during your visits with us, and your consent for photographs to be taken before, during, and after the procedure(s) for your patient chart.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_