Date: ______ / _____ / _____

_____ New Patient _____ Established Patient

PATIENT DEMOGRAPHICS:

First name:	Middle initial:	Last name:	Sex: ___M ___F
Date of Birth:	Social security#:	Marital status:	Email:
Address (include Apt#):	City:	State:	Zip:
Home #:	Cell #:	Work #:	Which is your primary phone #? ___ Home ___ Cell ___ Work
Occupation:	Employer:		
Race (Federal guidelines requirement): ___ White ___ Black or African American ___ Asian ___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander ___ Decline to specify Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Decline to specify			
If minor, parent/guardian name:	If minor, parent/guardian occupation:		
Primary care doctor:	Office #:	How did you hear about us?	

INSURANCE INFORMATION:

___ Check here if no insurance coverage / self-pay

Primary Insurance Company:	Policy ID #:	Group #:
Policyholder's Name:	Policyholder's Date of Birth:	Relationship to patient:
Secondary Insurance Company:	Policy ID #:	Group #:
Policyholder's Name:	Policyholder's Date of Birth:	Relationship to patient:

EMERGENCY CONTACT INFORMATION:

Name:	Phone:

RELEASE OF MEDICAL INFORMATION:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

MEDICAL INFORMATION:

Pharmacy Name & Location:	Pharmacy Phone #:
Allergies to Medications:	
Medications (including non-prescription and birth control):	
Have you had a flu shot? When?	

MEDICAL HISTORY:

- ○ Melanoma (year: _________)
- ○ Psoriasis
- ○ Asthma
- ○ Diabetes
- ○ Depression
- ○ High blood pressure
- ○ Hepatitis B or C
- ○ Pacemaker / Defibrillator
- ○ Ulcerative colitis
- ○ Fibromyalgia
- ○ MRSA
- ○ History of tuberculosis
- ○ Pregnant (wks: ___________)
- ○ Basal cell carcinoma
- ○ Eczema
- ○ Blood thinners
- ○ HIV/AIDS
- ○ Seasonal allergies
- ○ Joint replacement
- ○ Atrial fibrillation
- ○ Blood clots
- ○ Crohn's disease
- ○ Rheumatoid arthritis
- ○ Seizure disorder
- ○ Bleeding disorder
- ○ Breastfeeding
- ○ Squamous cell carcinoma
- ○ Cancer: ___________________
- ○ Coronary artery bypass
- ○ Organ transplant: ___________
- ○ Heart valve replacement
- ○ Liver disease
- ○ Thyroid disease
- ○ Congestive heart failure
- ○ Glaucoma
- ○ Lupus
- ○ Kidney disease
- ○ Dialysis
- ○ Trying to get pregnant

- ○ Other health conditions: ____

SURGICAL HISTORY:

Procedure:	Year:
Procedure:	Year:
Procedure:	Year:

FAMILY HISTORY:

Melanoma	○ Yes	○ No	Family member(s):
Cancer	○ Yes	○ No	Family member(s) / type(s):
Psoriasis	○ Yes	○ No	Family member(s):
Eczema	○ Yes	○ No	Family member(s):

SOCIAL HISTORY:

Tobacco use	○ Current	○ Former	○ Never	Type:	Amount:
Alcohol use	○ Current	○ Former	○ Never	Type:	Amount:

SIGNATURE:

Patient / Guardian Signature:	Date: