

General Dermatology Demographics Form

Name _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Phone number: Home _____ Cell _____ Work _____

Email address: _____

Primary Care Physician: _____ Phone: _____

Local Pharmacy: _____ Street _____ City _____ State _____ Phone _____

Individual that we can release medical information to if you are not available:

Name: _____ Relation: _____ Phone: _____

Primary Insurance _____ Secondary Insurance _____

Financial Consent

Surgical and Cosmetic Dermatology of Rhode Island has permission to bill my insurance company(s) for fees associated with my treatment. I will be responsible to pay my deductible, co-pay(s) and/or co-insurance. I understand it is my responsibility to get a referral from my primary care physician if my insurance requires it. I understand if I do not give the correct insurance information to this office I will be billed for the services.

Patient signature: _____ Date: _____

Photography Consent

I consent for medical photographs to be taken for the use of documentation in my medical record.

Patient signature: _____ Date: _____

Pharmaceutical History Consent

I consent for my pharmaceutical history to be obtained.

Patient signature: _____ Date: _____

Privacy Practices Acknowledgement

A copy of the Privacy Practices is at the check in window and hanging by the door. You can also request that one be sent to you.

I have been offered the Notice of Privacy Practices.

Patient signature: _____ Date: _____

Electronic Communication

I agree to the use of electronic communication, including email and text. I understand and agree with the AMA guidelines (H-478.997) as outlined in the handout available at the office.

Patient signature: _____ Date: _____

General Dermatology Medical History Form

Name: _____ Date of Birth: _____

HISTORY OF PRESENT ILLNESS

What are you here to discuss? _____

What are the symptoms? None Bleeding Itching Scabbing Pain Other _____

Have you had treatment before for this? No Yes (what kind) _____

REVIEW OF SYSTEMS

Overall, how do you feel physically? Excellent Good Fair

Heart Angina Defibrillator Pacemaker Heart failure Stents Heart murmur Heart attack
High blood pressure other _____

Psychiatric Anxiety Depression Frequent fainting spells other _____

Muscular/Skeletal Arthritis Joint replacement other _____

Pulmonary Emphysema Asthma Shortness of breath Chronic cough other _____

Hematologic Anemia Bleeding problems Bruises easily other _____

Cancer Breast Lung Lymphoma Prostate other _____

Healing problems Keloids other _____

Infections Disease High risk for AIDS Hepatitis Tuberculosis HIV+ other _____

Genitourinary Prostate issues Transplant Kidney disease Dialysis other _____

Liver Liver disease Cirrhosis Hepatitis ___ other _____

Gastrointestinal IBS Ulcers Reflux other _____

Neurological Seizures Stroke TIA other _____

Endocrine Thyroid Disease Diabetes type ___ other _____

Eyes Decreased vision Eye pain Glaucoma Constant tearing

Ears Decrease hearing Hearing aides

Nose Draining allergies Restricted breathing

Skin Abnormal moles Bleeding lesions Skin lesions Skin cancers Breast lumps Rashes
Eruptions Itching Sweating Darkened skin/pigmentation Lightened skin/loss of pigmentation

SURGICAL HISTORY: _____

ALLERGIES: _____

MEDICATIONS/SUPPLEMENTS: see attached

SOCIAL HISTORY:

Smoking Yes no former

Alcohol No Yes Daily Weekend Social occasions

FAMILY HISTORY:

Has any genetic family member had skin cancer? No Unknown Yes _____

Do you have an advanced care plan? Yes no

Do you have a health surrogate? Yes no

Female patients: Are you currently pregnant? No Yes # of weeks _____