



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.: _____

Secondary Insurance: _____

ID Number / Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship To

Patient: _____

Policy Holder D.O.B.: _____

Pharmacy (Please give exact address or cross streets.. excludes mail orders)

Name: _____

Address: _____

Mail Order Name: _____

Past Medical History

Current Conditions

- None
- Anxiety disorder
- Arthritis
- Asthma
- Atrial Fibrillation
- Benign Prostatic Hyperplasia
- Cerebrovascular Accident
- Chronic Obstructive Lung Disease
- Coronary Arteriosclerosis
- Depressive Disorder
- Diabetes Mellitus
- Disease caused by COVID
- Elevated Blood Pressure
- End-Stage Renal Disease
- Epilepsy
- Gastroesophageal Reflux Disease (GERD)
- History of Hypertension (high blood pressure)
- Hearing Loss
- Human Immunodeficiency Virus Infection
- Hypercholesterolemia (high cholesterol)
- Hyperthyroidism
- Hypothyroidism
- Inflammatory Disease of the Liver
- Leukemia
- Malignant Lymphoma
- Malignant Tumor of
 - Breast
 - Colon
 - Lung
 - Prostate
- Radiation Therapy Treatment Management
- Transplantation of Bone Marrow
- Other

Past Surgeries

- None
- Excision of Basal Cell Carcinoma
- Excision of Melanoma
- Excision of Squamous Cell Carcinoma
- Other, please specify

MEDICATIONS

Please list all current medications and supplements

ALLERGIES

Please list all current allergies; medications, seasonal, and environmental

Skin Disease History

Skin Conditions

- None
- Acne
- Actinic Keratosis (pre-cancer)
- Asteatosis Cutis
- Basal Cell Carcinoma of Skin
- Contact Dermatitis due to Poison Ivy
- Dysplastic Nevus of Skin
- Eczema
- History of Asthma
- History of Hay Fever
- Malignant Melanoma
- Pruritus (itching) of Scalp
- Psoriasis
- Squamous Cell Carcinoma of Skin
- Sunburn of Second Degree
- Other

Skin Protection

Do you wear sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Family History of Melanoma

Do you have a family history of Melanoma?

Yes No

If so, which family members?

SOCIAL HISTORY

Smoking Habits

What is your smoking status?

- Never Smoker
- Former Smoker- From _____ To _____
- Current Everyday Smoker
- Current Someday Smoker
- Current Chewing Tobacco user
- Current Vape user

Alcohol and Drug Use

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Do you consume alcohol?

- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

Do you use recreational drugs? Yes No

Do you use marijuana? Yes No

Occupation

What is your occupation? _____

What is your workplace? _____

Release of PHI (Protected Health Information)

Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____
Name _____ DOB _____ Relationship _____

I do not authorize anyone to have access to my medical records

QUALITY MEASURES (ONLY IF YOU ARE 65 OR OLDER)

Have you received a pneumonia vaccination on or after your 60th birthday? Yes No

Do you have a healthcare proxy? Yes No
Designee's name _____ Designee's phone number _____

Do you have a living will? Yes No

Which statement(s) best reflects your wishes on advanced care recommendations?

- Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

FAMILY HISTORY

Please list all pertinent medical history for the following family members

- Family History Unknown
- Mother _____
- Father _____
- Sister(s) _____
- Brother(s) _____
- Paternal Aunt(s) _____
- Paternal Uncle(s) _____
- Maternal Aunt(s) _____
- Maternal Uncle(s) _____
- Paternal Grandmother _____
- Paternal Grandfather _____
- Maternal Grandmother _____
- Maternal Grandfather _____